KILLYNETHER PRACTICE

CONSENT FOR 3RD PARTY TO DISCUSS MEDICAL INFORMATION

The use and sharing of personal information forms an essential part of the provision of Health & Care, benefiting individual patients, often necessary for the effective functioning of Health & Social Services and sometimes necessary in the public interest. Nevertheless your Doctor has a strong legal and ethical duty to protect patient information and all information you share with your Doctor is kept confidential.

Killynether Practice full DPIA can be viewed on our website www.killynetherpractice.co.uk

PATIENT DETAILS

Patient Name:	
Date of Birth:	
Address & Post Code:	
Telephone Number:	

NOMINATED INDIVIDUAL I WISH TO GRANT ACCESS TO

Full Name:	
Telephone Number:	
Address & Post Code:	
Relationship to Patient:	

WITNESS (Please ask another adult, other than your representative to witness your consent)

Witness Full Name:	
Witness Address and Post Code:	
Witness Signature:	
Date:	

EXTENT OF CONSENT

ALL Medical Information ☐

OR SPECIFY BY TICKING THE RELEVANT BOXES BELOW

Appointment Date/Times ☐ Medication ☐ Medical History ☐

X-Ray/Scan Results ☐ Lab Tests/INR Results ☐ Other ☐ (Please Specify)

_____

_____

DURATION OF CONSENT

This authorisation will remain in effect from the date signed below until (please tick):

☐ _____ (specify expiration date or event)

☐ NO EXPIRATION DATE

DECLARATION

- I am a Patient of Killynether Practice and understand I need to give consent for another individual to have access to my Medical Records in order to discuss my Medical Requirements.
- I understand the contact details of the individual will be recorded on my Medical Record.
- I understand that if any of the consent contact details change or I wish for them to be removed from my Medical Record I will contact the Surgery immediately.
- **I CONSENT TO THE RELEASE OF CONFIDENTIAL INFORMATION FROM MY MEDICAL RECORD AS INDICATED ON THIS FORM TO THE NOMINATED INDIVIDUAL.**

Signature of Patient:_____

Date:_____