Consent form

Consent to share information with a nominated third party

Patient name;……

Patient date of birth;……

Patient address;……

……

Postcode;……

I CONSENT TO THE PERSON/PERSONS NAMED BELOW TO BE ALLOWED TO BE INFORMED OF (PLEASE TICK AS APPROPRIATE) IF YOU ARE UNABLE TO CONTACT ME DIRECTLY.

- **APPOINTMENT BOOKINGS/CANCELLATIONS**
- **MEDICATION QUERIES**
- **GENERAL ENQUIRIES**
- **SPECIFIC QUERIES RELATING TO MY MEDICAL RECORD**

Nominated contact details (up to 2 people)

(1) Full name;……

Telephone number;……

Address;……

(2) Full name;……

Telephone number;……

Address;……

PATIENT SIGNATURE……

DATE……

I am aware I can cancel/amend this nomination at any time by informing a member of the practice staff in writing and my record will be amended accordingly.

N.O.K details ☐ **(Tick this box if the details are the same as above)**

Name;…… D.O.B;……

Address;……

Relation to you;…… Tel;……