**The Nuffield Practice**

**Patient Consent Form - for another person to access their medical records**

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| **Patient’s Details -(The person whose records another individual(s) is to be given access to)** |
| **Title** |  |
| **Full Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Telephone No.** |  |

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| **Details of person to be given access to this Patient’s information** |
| **Title** |  |
| **Full Name** |  |
| **Are they registered at this practice?** | **Yes**  **No** |
| **Relationship** |  |
| **NHS No (if not registered here)** |  |
| **Date of Birth** |  |
| **Telephone No.** | **Home: Mobile:** |
| **Address** |  |
| **List as your next of kin?** | **Yes**  **No** |
| **List as an emergency contact?** | **Yes**  **No** |

**(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)**

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| **Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)** |
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| **I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.** |
| Signature |  |
| Date |  |