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**Patient Consent Form**

For another person to receive details of medical treatment/results etc. on my behalf

Patient’s Details:

Full Name:

Male / Female:

DOB:

Address:

Tel/Mobile NO:

I confirm that I give permission for the Practice to communicate with the person identified below in regard to my medical record information, i.e., results, appointments etc.

Signature

Date

Details of person to be given access to this Patient’s information

Full Name:

Male / Female:

DOB:

Address:

Tel/Mobile 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)

\*PLEASE INFORM US SHOULD THESE CIRCUMSTANCES CHANGE\*