

## Authorisation for Access to Patient Records

Patient Name:

Date of Birth:

NHS Number:

I hereby give permission for the following person(s):

Name:

Relationship:

Contact details:

to have access to the following information from my medical records:

- Appointment information
  - Prescriptions and medication
  - Consultations
  - Test results
  - Referrals / Hospital Correspondence
  - Other (please specify below)
- 

Patient name (PRINT) .....

Patient signature ..... Date: .....