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:
(please sign under each part of your record to which you consent to give access)

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

Date ……..