**CONSENT TO SHARE INFORMATION**

This form is for patients who wish a family member, guardian or legal executive to have access to their medical records. By signing this form, it will give your nominated person the right to have access to appointment information, test results, information about any medication you are taking and any aspects of your current or past health. Once completed, this form will be scanned into your medical records and a note made that you have given your permission. Our staff will then be happy to talk to the person you nominate. Without a signed form, we are unable to disclose any information for reasons of confidentiality.

PLEASE NOTE THAT IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THE PRACTICE IN WRITING IF YOU NO LONGER WANT THE PERSON(S) NAMED ON THIS FORM TO HAVE ACCESS TO YOUR MEDICAL INFORMATION.

I ………………………………………………..................................... DOB ……………………………………

 (Name)

**Give consent to:**

Name…………………………………………………………………………………..

Address……………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………

Telephone number…………………………………………………………………………………………………..

**To have access to the following aspects of my medical information**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Test Results** |  |  |
| **Appointment information** |  |  |
| **Personal information** |  |  |
| **Medication** |  |  |
| **All aspects of my medical record** |  |  |

Signed…………………………………………………………………………………….

Print name…………………………………………………………………………….. Date ……………………….