Arlington Road Medical Practice

Consent to Share Form

Patient Details	
Name	
DOB	
Address	

I give the Surgery consent to disclose my private medical information to the person(s) named below:	
Name	
Relationship	
Address	
Tel No.	
Name	
Relationship	
Address	
Tel No.	

Please tick the level of disclosure you wish to give below:	
Full and open ended disclosure of any matter related to my medical record	☐
Full disclosure of any matter related to my medical record for the following period: **Date from** ___/___/_____ **Date to** ___/___/_____	☐
Limited disclosure of the following aspects of my medical record:	
Test Results	☐
Prescriptions Queries	☐
Appointment Queries	☐
Referral Queries	☐
Other, please state:	☐

This consent is valid from today's date	___/___/_____	End Date	___/___/_____
Please specify end. If no date is specified, the Surgery will accept this as a permanent instruction.			
I am aware that this consent can by revoked by me at any time.			☐

Signature		Date	___/___/_____