CHURCHTOWN MEDICAL CENTRE
137 Cambridge Road, Southport, PR9 7LT
Tel: (01704) 224416 Fax: (01704) 507168

Patient consent form

Please complete this form to give authority to a Third party to discuss your medical queries

Patient Details

Surname:………..

First Names:……..

Date of Birth:………………………………………………… Male/Female:……………………………..

Reason for giving consent:……………………………………………………………………………………..

Third Party Details

Full Name:………

Relationship to patient:………………………………………………………………………………………

Date of Birth:…………………………………………………... Male/Female:…………………………….

Telephone Number:…………………………………………………………………………………………

I confirm that I ………………………………………………………………

- Give my consent for Churchtown Medical Centre staff to discuss my medical queries and order medication with……………………….……………………..…………on my behalf.

PLEASE CHOOSE WHICH LEVEL OF DISCLOSURE YOU AGREE TO

- Discuss medical records
- Appointments
- Medication

IS THERE A SPECIFIC TIME FRAME FOR THIS DISCLOSURE?

- YES (please enter dates) From……….……………….………To…………………………….
- No, I understand that the authority will remain on my records indefinitely and I must contact the practice to cancel the agreement.

Signature of patient:………………………………………………………… Date:……………………

Signature of authorised third party:………………………………….. Date:…………………….

Office Use

Patient contacted verbally to check they agree with consent YES/NO
If patient is unable to be contacted or unable to give verbal consent then this form is not valid
Date of verbal confirmation……………………………………………………………………….
Staff signature gaining verbal consent……………………………………………………….
Codes to add to records: Consent given to share patient data with specified third party **YES/NO**