PENN MANOR
MEDICAL CENTRE

Consent for discussing medical history, investigation results and appointments for a patient

Details of the patient:

Surname	Date of birth
First name	
Address:	
Email address	
Tel:	Mobile:

I wish to give access to the following information about my medical history (please tick all that apply):

1. Booking/booked appointments	❑
2. Requesting repeat prescriptions or discussing my medication	❑
3. Requesting results of tests	❑
4. Talking to my GP about my medical history and care	❑

I wish to give access to the following person to be able to discuss the above about my medical care:
(if there is more than one person you wish to be able to do this, please complete separate forms)

Surname:	
First Name:	
Contact Address:	
Contact Mobile:	Home Number:
Relationship to the patient:	
Signature of the patient giving consent:	

For practice use only to verify the identity of the patient consenting, this needs to be face to face with the patient and ID

Patient NHS number:		
Identity verified by: (initials)	Date:	Method Vouching ❑ Vouching with information in record ❑ Photo ID and proof of residence ❑
Authorised by:		Date