The Roxton Practice

Patient consent to release information relating to medical information to a named individual

Patient's Details (This is the person giving consent to a 3rd party)	
Surname	
First Names	
Date of Birth	
NHS No.	
Address	
Telephone Number	

I confirm that I give permission for the Roxton practice to release information to the person identified below relating to (please tick)

- Test Results (giving of results and related directions) ☐
- Appointment management (booking, checking and cancelling) ☐
- Medication (requesting and discussing medication/prescriptions) ☐
- Other (please give details) ☐

- I understand that this consent form is valid for 24 months only. On expiration of the consent the patient may wish to complete another consent form.
- I also understand that the Roxton practice reserves the right not to share any information that is deemed by the GP to be not in the patient's best interest.

Signature	
Date	
Identification	

3rd Party Details (this is the person with whom the patient consents to sharing information regarding their medical information).	
Surname	
First Names	
Date of Birth	
Address	
Relationship to patient	
Indentification	

(if more than one person is to be given access please complete another form)

FOR OFFICE USE ONLY	
Action	**Date**
Reminder set with expiration date	
Added to record (groups & relationships)	
Name of staff member	