**Moorland Medical Centre**

**Patient Consent Form   
for another Person to Access their Medical Records**

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| --- | --- |
| **Patient’s Details**  **(The person whose records another individual(s) is to be given access to)** | |
| **Surname** |  |
| **First Names** |  |
| **Date of Birth** |  |
| **Male / Female** |  |
| **Address** |  |
| **Tel No.** |  |

I hereby consent to the disclosure of my private medical information to:

|  |  |
| --- | --- |
| **Details of person to be given access to this Patient’s information** | |
| **Full Name** |  |
| **Address** |  |

(if more than one person is to be given access, please list the above details for each additional person on a separate sheet of paper)

Please tick the statement/s applicable:

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 period

*(From) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (To) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Limited disclosure of the following aspects of my medical record:*

 Test Results  Appointment Queries

**** Prescription Queries **** Referral Queries

Collection of my prescription by a third party

 Any other matter related to my medical record, please state:

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**I am aware that this consent may be revoked by me at any time, in writing to the Practice Manager.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

Witnessed by (not the individual for whom consent is being granted):

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If you need assistance in completing this form please contact the Practice Manager.**

**Consent for children under 16 (Gillick Competence)**

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

**I am the Patient / Parent / Guardian (delete as necessary).**

**Signature**: ……………………………………………………………………………………………………………………………..…..

**Full Name**: …………………………………………………………………………………………………….……..………….……....

**Address (if not the same as patient):**

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**Admin Use Only**

**Coding of records**

9qA – consent given for collection of prescription by specified third party

9NdG – consent given to share patient data with specified third party

Dated: May 2018

Review Due: May 2019