

## 3rd PARTY CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

To gain access to another person's medical records, you need to complete the form below and arrange for it to be signed by the patient concerned.

You will need to bring this completed form to the surgery with at least one form of photographic ID for the consent to be approved with the patient present. Verbal confirmation will be required for housebound and care home patients.

1) Full disclosure to discuss anything held within my medical record

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OR

2) Disclosure is limited to test results, prescription queries and appointments

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Patient's Name	
Patient's Date of Birth	
Patient's Address	
Patient's signature	
Relationship of person applying for access to the patient	
Name of person applying for access	
Date of Birth of person applying for access	
Address of the person applying for access	
Telephone Number(s) of the person applying for access	
Email address of the person applying for access	
Signature of the person applying for access	
Date	

**FOR OFFICE USE ONLY:**

ID Document: \_\_\_\_\_

Name of Receiving Staff Member: \_\_\_\_\_

Date: \_\_\_\_\_

**ADMIN ACTIONS**

Scan to Patient Record ☐

Add note to Blue Bar noting full or partial disclosure, date added and initials ☐