HEATH LANE SURGERY

CONSENT / PERMISSION TO DISCLOSE DATA TO A NAMED THIRD PARTY

Name of patient…….D.o.B. ……

Address …….

……

Telephone Nos ……..

I hereby consent and give permission for Heath Lane Surgery to disclose information regarding my medical conditions to the following named third party person:

Name ……

Address ……

……

Telephone Nos …….

Relationship to patient …….

If there are any special terms you would like to express please give details below:

……..

……..

……..

……..

On signing this form please note that information given out may be regarding medical problems as well as current or future conditions. If there are any medical conditions or any part of your medical records that you do not wish the above person to be informed about you must notify us.

I understand that this agreement will continue until I notify you otherwise.

Signature of patient ……... Date ……