**Patient Consent Form for another person to access their medical record.**

**(Including for patients request proxy access for children under 16)**

|  |  |
| --- | --- |
| **Patient’s Details**  **(The person giving access)** | |
| Surname |  |
| First Names |  |
| Date of Birth |  |
| Address |  |
| Telephone Number |  |
| NHS Number |  |
| **Details of person accessing this patient’s information (requestor)** | |
| Surname |  |
| First Names |  |
| Date of Birth |  |
| Address |  |
| Telephone Number |  |
| Email Address  *(for Online access)* |  |
| Relationship to patient. |  |

**Details of access to be granted.**

|  |  |
| --- | --- |
| **Face to Face and Telephone Contact** | |
| (tick all appropriate) | |
| Appointment booking |  |
| Test results |  |
| Prescription ordering and queries. |  |
| Full medical record access. |  |

|  |  |
| --- | --- |
| **Online Access Only (proxy)** | |
| (tick all appropriate) | |
| Appointment booking |  |
| Prescription Management |  |
| Full medical record access |  |

|  |  |
| --- | --- |
| **Duration of consent. (F2F & telephone)** | |
| (tick appropriate) | |
| Until (specify date) |  |
| Indefinitely |  |

|  |  |
| --- | --- |
| **Duration of consent. (online)** | |
| (tick appropriate) | |
| Until (specify date) |  |
| Indefinitely |  |

I understand fully the implications of this regarding my confidential medical information and understand that it is my responsibility to renew this consent yearly or remove my consent if my wishes change.

My consent is relating to information held by Meon Medical Centre only, and no other organisation.

**Signed: ………………………………………………… DATE: ……………………………………**

Practice use only.   
Patient ID Seen? □ Requestor ID Seen? □

ID Verified - Staff member name: ……………………………. Patient number………………………………