LONG BENNINGTON
Medical Centre

Long Bennington Medical Centre
Consent to Disclose Medical Information to Next of Kin/Relative

Please complete both sides of this form. The form will need to be signed in the presence of a witness (not the individual for whom consent is being granted)

PLEASE COMPLETE IN BLOCK CAPITALS

Patient Details

Patient Full Name……

Date of Birth…… **Telephone No**……

Address……

……

Postcode……

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

Full Name……

Date of Birth…… **Telephone No**……

Address……

……

Postcode……

Relationship to the Patient named above……

I consent to the limited disclosure of the following aspects of my medical record/information:

Test results	☐
Prescription queries	☐
Appointment queries	☐
Referral queries	☐
Any other matter related to my medical record, please state	☐
AskMyGP requests	☐

Date from……To……

Have you nominated someone to speak on your behalf (e.g. a person who has Lasting Power of Attorney for your Health and Welfare?) Yes ☐ No ☐

If yes, please provide details of the nominated attorney. The Practice will also need to see the ORIGINAL Lasting Power of Attorney which will be copied and kept on record.

I AM AWARE THAT THIS CONSENT MAY BE REVOKED AT ANY TIME BY ME AND THAT IT IS MY RESPONSIBILITY TO INFORM THE PRACTICE OF MY DECISION

Patient signature…….. **Date**…….

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

Name of witness……**Signature**……

Address……

……

Postcode……..

IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE SPEAK TO A MEMBER OF OUR RECEPTION TEAM.