**The completion of this form will authorise Tile House Surgery to discuss information regarding your health needs with the third party named in Section 2.**

This information will be noted on your medical record.

You can withdraw this consent at any-time.

**Section 1:**

Details of the Patient

|  |  |
| --- | --- |
| Patients Full Name |  |
| Date of Birth |  |
| Contact Telephone Numbers |  |

**Section 2:**

Details of the named third party

This is the person who will be able to access your medical records, be given information about current and past health issues, repeat prescriptions, test results and make appointments.

|  |  |
| --- | --- |
| Full Name |  |
| Address |  |
| Contact Telephone Numbers |  |
| Relationship to Patient |  |
| Is this person to be listed as Next of Kin? | YES/NO |

|  |  |
| --- | --- |
| Please confirm this person can also have online access to your record? Please circle the type of access you wish this person to have access to  | YES/NODETAILED CODED (just codes relating to diagnosis)FULL CLINICAL(every entry made into your clinical record) |
| If person named in section 2 is not registered at Tile House, the patient will need to provide the online signing details.If person named in section 2 is registered at Tile House, we can give access via their online access. |

**If a patient has ‘Lack of Mental Capacity’ and is unable to consent to this request, we would need a copy of a ‘Health and Welfare Lasting Power of Attorney’ evidencing your entitlement to access this information.**

**I confirm that I am the patient and have capacity to make this decision -**

**Third Party Authorisation**

I hereby consent & authorise Tile House Surgery to release any personal data they may hold relating to me to:-

(Enter the name of the person acting on your behalf as named in section 2)

Signature of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (Printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_