Colwall Surgery

Agreement by a Patient to allow Next of Kin / Carer to have access to their Personal Details and / or Copies of Correspondence.

Patient's Name	
Patient's Address & Post Code	
Next of Kin/Carer's Relationship to patient	
Next of Kin/Carer's Contact information *(if necessary)*	

I give permission for my Next of Kin / Carer (delete as appropriate),…… to have access to my personal details and medical records held by the Practice.

Please cross out those which are NOT applicable:

This permission relates to all my records.

The permission relates to part of my records.	
Please specify the parts of the record to which access is allowed and any areas which are specifically excluded.	

This permission relates to a specific condition.	
Please specify the condition.	

The permission relates to my Next of Kin / Carer receiving copies of all correspondence relating to my treatment.
I confirm that my GP has explained this to me and has sole discretion to withhold any or all copies.

I understand that this permission will remain in force until cancelled by me in writing and that the doctor may override this authority at any time.

I consent to my Next of Kin / Carer receiving copies of all correspondence relating to my treatment (delete if not applicable). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed Patient: _____ Date: _____

Accepted by Doctor: _____ Date: _____

Office Use Only:

Copy Frequency	
Specific Copy Exclusions	
Specific Copy Inclusions	