Howard Medical Practice

**Patients 13yrs to 16yrs**

**Consent to add contact details to Medical Record**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name** | | **D.O.B** | **Post Code** | |
|  | |  |  | |
| I confirm that I would like my own contact details included on my medical record: | | | | |
| **Home Tel:** |  | | | |
| **Mobile:** |  | | | |
| I confirm that I would like my parent/carer’s contact details included on my medical record | | | | |
| **Home Tel:** |  | | | |
| **Mobile:** |  | | | |
| |  | | --- | | **Signature of patient** | |  | | **Date** | |  |   **I understand that I have the right to change my mind at any time and can amend these details by giving further written consent** | | | | |