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:** |  |
|

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| --- |
| **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** |