**Howard Medical Practice**

**Patient Consent Form**

For 3rd Party Access to Medical Records

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| **Patient Details**(individual whose medical information is to be disclosed) |
| **Surname** |  |
| **Forename(s)** |  |
| **Date of Birth** |   **M / F** |
| **Full Address** |  |
| **Tel No.** |  |

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| **Details of 3rd Party to be given access to information** |
| **Name of 3rd party** |  |
| **Address** |  |
| **Tel contact** |  |
| **Email**  |  |

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| **Access required/Information to be disclosed** |
|  *Please tick* |
|  | **Full records** *(as required)* |  | **Summary only** |
|  | **Limited records** |
| *If* ***limited records****, please state below the specific access that you consent to:* |
| **From \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_** *Please tick* |
|  | **Current medication** |  | **Referrals** |
|  | **Past medication** |  | **Investigations**  |
|  | **Current diagnosis** |  | **Attended appointments** |
|  | **Past diagnosis** |  | **Missed appointments** |
|  | **Consultations** |  | **Letters & documents** |

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| I confirm that I give my full consent for the practice to communicate with the 3rd party stated above in respect of the medical information/access as indicated |
| **Signature** |  |
| **Print full name** |  |
| **Date** |  |

I am the **Patient** **Parent of the above child under 16yrs with whom I have parental responsibility**