Patient Consent Form for the Sharing of Data

To be used when the patient agrees to information sharing with another person

Clear Form eMail

Patient's Details

Forename(s) _____ **Surname** _____

Date of Birth _____

Address _____ **Telephone Number** _____

eMail Address: _____

I hereby give consent for Macduff Medical Practice to:

Leave a telephone message for me to contact the Medical Practice ☐

Share the following medical information: ☐

Please state the general nature of information which can be provided. Please note that the Medical Practice reserves the right to further question, and/or otherwise identify with the patient in order to ascertain the certainty of the request.

_____

With the following named person(s) / Organisation:

_____

Telephone Contact number _____ **Relationship to patient** _____

eMail Address: _____

I wish to see the information before it is made available to the aforementioned third party **Yes** ◯ **No** ◯

Patient Signature: _____ **Date:** _____