Patient Consent Form for the Sharing of Data

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

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:**