**ANTONINE MEDICAL PRACTICE**

**Consent form**

**(for another individual to discuss my medical record/Care)**

**Patient details**

|  |  |
| --- | --- |
| **Patient name** |  |
| **Date of birth** |  |
| **Address****Postcode** |  |
| *I am a patient of Antonine Medical Practice and understand I need to give consent for another individual to have to discuss my medical requirements/care. I understand the contact details of the individual will be recorded on my medical record.***Signature of patient/ guardian:****Relationship to patient:** **Date:**  |

**Contact details for the individual who I wish to grant access**

|  |  |
| --- | --- |
| **Full name** |  |
| **Telephone number** |  |
| **Relationship to patient** |  |

I understand if any of the consent contact details change or I wish for them to be removed from my medical record I will contact the Practice immediately. A ‘remove/ change to consent form’ is available from our Reception.

**(Please tick)**