**Antonine Medical Practice**

**Removal or update of consent form**

**(To remove or update the details of another individual who has can discuss my medical requirements/care)**

**Patient details**

|  |  |
| --- | --- |
| **Patient name** |  |
| **Date of birth** |  |
| **Address****Postcode** |  |
| *I am a patient of Antonine Medical Practice and I have previously given consent for another individual to discuss my medical requirements/care. I wish for their details to be updated or removed from my medical record.***Signature of patient:****Date:**  |

**Contact details for the individual who I wish to remove from my medical record**

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

**New contact details for the individual who I wish to grant access**

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