Phoenix Health Group

Consent to discuss my health with someone else.

What you will need:

- For the representative and Patient to provide ID to Reception (Drivers Licence, Passport…etc)

Section 1

I, …….(name of patient), give permission to my GP practice to give the following person …… the ability to be able to discuss my health on my behalf with the practice.

- I reserve the right to reverse any decision I make in granting this access at any time.
- I understand the risks of allowing someone else to have access to my health information.

What can be shared with this person:

- To be given **test results and immunisation records.**
- To be able to discuss questions about **my medication** or prescription requests.
- To be able to **ask details of my appointments** – e.g., times and dates, to be able to cancel appointments and **make** appointments where necessary.
- To be able to discuss any **referrals** that have been made on my behalf.

Signature of Patient	Date

Section 2

I……(name of representative) wish to be able to discuss the health of the patient with the practice.

For ……(name of patient).
I understand my responsibility for safeguarding sensitive medical information, and I understand and agree with each of the following statements:

1. I understand and agree that I will treat the patient information as confidential.	
2. I will be responsible for the security of the information that I see or download.	
3. I will contact the practice as soon as possible if I suspect that the information has been accessed by someone without my agreement.	
4. If I see information in the records that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential.	

Signature of representative	Date

Section 3

The patient

Surname:	Date of birth:
First name:	NHS Number:
Address:	
Email address:	
Telephone number:	Mobile number:

The representative/parent

Surname:	Date of birth:
First name:	NHS Number:
Address:	
Email address:	
Telephone number:	Mobile number:
Relationship to Patient:	

For practice use only

Identity verification	Photo ID of the Patient: ☐ Form of ID …….. Photo ID of the Representative: ☐ Form of ID …….. If this is not recorded, then access will not be given.	Name of ID verifier	Date
Approved by Name…… Date …….			