**CONSENT TO SHARE INFORMATION WITH RELATIVE/CARER**

**PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 I **give consent for my relative/carer (named below) to have access to my medical records and personal details held by the Practice and for staff to discuss my medical care with them.**

|  |  |
| --- | --- |
| **RELATIVE/CARER DETAILS** |  |
| **NAME**  |  |
| **ADDRESS** |  |
| **RELATIONSHIP TO PATIENT** |  |
| **CONTACT TELEPHONE NUMBER** |  |

 **To be completed by the relative/carer.**

**I the above agree that any medical information I receive will be treated with confidentiality and respect for the patient.**

**Relative/Carer Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by the patient.**

**I understand that this consent will remain in force indefinitely. However, should I wish consent to be withdrawn I will contact the surgery to inform them of this change.**

**Signed.............................................................................. (Patient)**

**Date..................................................................................**