CONSENT FOR SPECIFIED PERSON TO HAVE ACCESS TO A PATIENT'S MEDICAL RECORD

Patient's Name	
Date of Birth	
Patient's Address	

To: St Austell Healthcare

I give permission for ____

(Relationship to patient________________________________) to have access to

my medical records and personal details held by the Practice.

This permission relates to (PLEASE TICK AS APPROPRIATE)

All of my record	
Part of my record	
Specific condition	

Where the permission is restricted to part of the record only, or a specific condition, please specify below the precise limits of this permission, and any areas of the record which are excluded.

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I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

Signed ________________________________ (Patient)

Date __________________________________

To be completed by SAH staff member:-

Name of patient's photo ID Documentation seen ______________________________

Date seen _____/_____/_____

Staff Members Initials __________

Reviewed November 2018