AUTHORITY TO DISCUSS MEDICAL DETAILS, MEDICATION AND HISTORY

I ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: relationship:

Permission to discuss with the surgery my medical details, medication and history

The practice will treat this as valid for the duration of your registration at the practice. I understand if I wish to withdraw consent I will need to notify the surgery in writing.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Authoriser & Patient

Witnessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness name & Relationship (not family):

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please be advised the witness cannot be the person who has been given authority or a family member