STATION VIEW HEALTH CENTRE

**Patient Consent Form**

**For another person to access their medical records**

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| --- |
| **Patient’s Details** |

|  |  |
| --- | --- |
| Surname |  |
| First Names |  |
| Date of Birth |  |
| Male/Female |  |
| Address |  |
| Tel No. |  |

|  |
| --- |
| Details of person to be given access to this Patient’s information**You need to make this person aware the surgery will be holding their personal contact information on your patient records and they will need to sign so we know they have given consent to this** |

|  |  |
| --- | --- |
| Full Name |  |
| Address |  |
| Tel No. | Home Work Mobile |

|  |  |
| --- | --- |
| Relationship to patientAre you a carer for this patient Yes / No  | Emergency Contact Yes / NoNext of Kin Yes / No |

|  |
| --- |
| I consent and understand that my details as completed above will be held on the records of the above patient Print Name Signature Date |

(if more than one person is to be given access please ask for an additional form)

|  |
| --- |
| **Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making and cancelling appointments, collecting scripts or for a specified time period only)** |
|  |

|  |
| --- |
| **I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records** |

|  |  |
| --- | --- |
| Signature |  |
| Date |  |

**Consent for children under 14 (Gillick Competence)**

Everyone aged 14 or more is presumed to be competent to give consent for themselves, unless the opposite is

demonstrated.

If a child under the age of 14 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

**I am the Patient / Parent / Guardian (delete as necessary).**

Signature: …………………………………………………………………………………………………………………..…..

Full Name: ….……………………………………………………………………………………….……..………….….…....

Address (if not the same as patient):

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