NHS
University Health Service

Consent to allow access to medical information for a third-party

Section 1 – Foreword

Please complete this form if you wish to grant a representative the ability to communicate with us about you. This will enable them to gain information about you and your medical problems, talk to us about your care, and give and receive information about you. It will not entitle them to order copies of your medical records, sign consent on your behalf, withdraw care or sign an order to prevent your resuscitation.

Giving consent to someone else to communicate with us about you and your medical problems is a very significant step and you should ***give it serious consideration before you give consent***. You need to consider what they might learn about you and your problems that you did not want them to know and have fully considered the ramifications of giving that consent. Once they learn information about you, they might also share it with others that you did not intend to have that information. If you are unsure about giving consent, we advise that you do not give it and that you seek legal advice before proceeding.

Section 2 – Patient's details

Title (please tick one):	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other:
Surname/Family name:	
Forename(s):	
Date of Birth (D/M/Y):	☐☐ / ☐☐ / ☐☐☐☐
NHS No. (if known):	☐☐☐ ☐☐☐ ☐☐☐☐
Telephone number:	
Email Address:	
Current Address:	
Postcode:	

Please complete page 2 >>

Page 2 – please repeat	
Patient name:	
Patient date of birth:	

Section 3 – Representative's details	
Title (please tick one):	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other:
Surname/Family name:	
Forename(s):	
Telephone number:	
Email Address:	
Relationship to patient:	

Section 4 - Extent of consent
We need to know what problems you wish to give consent for the third-party to communicate with problem(s) for which you are giving consent. **You cannot state 'everything' or 'all problems'.**

Section 5 – Duration of consent	
This consent will be valid for either up to **six months** from signing or **until the above problem(s) resolve** (whichever occurs sooner). If you wish your consent to last for a shorter period of time than this, please specify an earlier end date for your consent:	
Duration:	☐ Maximum six month period ☐ Until: __ __ / __ __ / 20 __ __

Section 6 – Patient's signature	
I have read the foreword above and consent to the release of confidential information to the person stated in section 3.	
Patient's signature:	
Date of signing:	☐☐ / ☐☐ / 20 ☐☐

Section 5 – Witness' signature	
Please ask another adult, who is not the representation given in section 3, to witness your consent.	
Witness' signature:	
Date of signing:	☐☐ / ☐☐ / 20 ☐☐
Witness' name:	
Witness' address:	

Please return this form to the practice::
Post: University Health Service, Building 48, University of Southampton, Highfield, Southampton SO17 1BJ
Email: surgery@unidocs.co.uk
Hand: Please hand in to reception