

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

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.

YOUR DETAILS
Full name:
Date of birth:
NHS No (if known):
Address:
Mobile:
Home:
Work:
Email:

YOUR REPRESENTATIVE'S DETAILS
Name:
Address:
Mobile:
Home:
Email:
Their relationship to you: <input type="checkbox"/> Parent <input type="checkbox"/> Wife/Husband/Civil partner <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Other (please state relationship):

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

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: _____ / _____ /20_____

Declaration
I consent to the release of confidential information from my medical record as stated in this form to the person stated above
Signed: _____ Dated: _____

Witness (please ask another adult, other than your representative, to witness your consent)	
Witness full name:	Witness signature:
Witness address:	Dated: