

MILLVIEW MEDICAL CENTRE

CONSENT TO ACCESS MEDICAL RECORDS

To Reception Millview Medical Centre
(tick as appropriate)

1 Sleaford Road
Heckington
Sleaford
Lincolnshire
NG34 9QP

29 Handley Street
Sleaford
Lincolnshire
NG34 7TQ

Patient Name _____

Patient NHS Number _____

(please contact the surgery if you are unsure of this)

Patient Date of Birth _____

Patient Address _____

I hereby give consent for Millview Medical Centre to release the following information to:

Name of Authorised Individual _____

Relationship to Patient _____

Password _____

(please advise the authorised individual of your chosen password as medical information will only be disclosed to your authorised individual on correct disclosure of the chosen password. Passwords can only be reset by the patient and we will note your password on our computer system.)

I consent to disclosure of the following information (please tick all that are appropriate):

All medical information (including that of a sensitive nature and below categories)

All medical information (excluding that of a sensitive nature but including below categories)

Blood test results only

Medication Information

Results of investigations (e.g. blood tests, x-rays, hospital referrals)

Please note this consent will be held on your medical record until such time as you ask us to remove it. Please remember to notify us if your circumstances change.

Signed _____

Dated _____

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Responsibility: Practice Manager

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