**Millview Medical Centre  Millview Medical Centre**

**Heckington Surgery contact : 01529 460213 Sleaford Surgery contact : 01529 305595**

**CONSENT/PERMISSION CONFIDENTIALITY FORM**

**FOR a CARER or PERSON GIVEN CONFIDENTIALITY PERMISSION**

**Dear Patient,**

**Our Practice is committed to maintaining Patient Confidentiality and will only give patient information and results to you the patient. If you would like us to give information about your Healthcare to a relative or carer – please confirm your consent/permission by completing the details below.**

**PATIENT NAME …………………………………………………………………….. DATE OF BIRTH……………….………………….**

**PATIENT NHS NUMBER ………………………………………………………….**

**PATIENT ADDRESS…………………………………………………………………………………………………………………………………**

**………………………………………………………………………………………………TELEPHONE :……………………………………….…**

**DO YOU PREFER TELEPHONE CONTACT BY US ONLY TO YOUR AUTHORISED PERSON - Yes / No…………….**

**IF YES PLEASE STATE WHY: eg Hard of Hearing, Mobility Issues ................................................................................................................................................................................................**

**……………………………………………………………………………………………………………………………………………………………….**

**I CONSENT TO INFORMATION ABOUT MY HEALTHCARE BEING GIVEN TO :**

**NAME OF AUTHORISED PERSON……………………………………………………….DATE OF BIRTH……………………………**

**ADDRESS………………………………………………………………………………………………………………………………………………..**

**……………………………………………………………………………………………….TELEPHONE…………………………...................**

**RELATIONSHIP TO THE PATIENT………………………………………………………………………………………………………………**

**PASSWORD…………………………………….EMERGENCY CONTACT NUMBER…………………………………………………….**

 **Please make sure that you and the patient both know**

 **this password – information will not be given without it.**

**PLEASE TELL US WHAT INFORMATION YOU ARE HAPPY FOR US TO DISCLOSE (TICK ALL RELEVANT BOXES ) :**

** - MEDICATION INFORMATION ONLY**

** - RESULTS OF INVESTIGATIONS, REFERRALS AND BLOOD TESTS ( EG : PENDING APPOINTMENTS, X-RAYS, ECG, SCANS )**

**SIGNATURE OF PATIENT…………………………………………………………………………………………………..**

 **DATE……………………………………………. ( Please note this consent will be held on your medical record**

 **until such time you ask us to remove it. )**

**FOR OFFICE USE ONLY**

**Information added to Patient’s Home Page inc which boxes are ticked SIGN……………………………..………………..DATE.....................................**

**Information added to Patient’s Groups & Relationships Page SIGN………………………………….………………..DATE………………………………….**

**Document scanned and attached using letter type CONSENT FORM into Patient’s record SIGN………………….………..DATE………………….…………**