**Billericay Medical Practice**

# **Consent Form for Release of Information to a Third Party**

I (insert name of patient/recipient of care)

…………………………………………………………………………………………………DOB……………………………………

Of (insert address of patient/recipient of care)

………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………….

Do hereby give my consent for (insert name of person acting on your behalf)

…………………………………………………………………………………………………DOB…………………………………….

Of (insert address of person acting on your behalf)

……………………………………………………………………………………………………………………………………………….

………………………………………………………………………………………..Tel No…………………………………………

To request information regarding my medical history/results/or any other relevant information held by the surgery.

I understand that the information released under this authority may include both clinical and non-clinical information relating directly to me.

Signed (Patient)……………………………………………………………………………Date………………………………………….

(If the named patient is not able to sign for themselves, then please phone reception for further advice.)