HIGHLANDS SURGERY

CONSENT FORM

THIS FORM MUST BE COMPLETED BY THE PATIENT GIVING CONSENT

Name: Mr/Mrs/Miss		**DOB:**	
Address:			
Telephone:		**Mobile:**	
Email:			

WHO WOULD YOU LIKE TO GIVE CONSENT TO?

Name: Mr/Mrs/Miss		**DOB:**	
Address:			
Telephone:		**Mobile:**	
Email:			
Relationship:			
Is this person registered at Highlands Surgery?		**Yes**	**No**
Is this person your next of kin?		**Yes**	**No**
Is this person your emergency contact?		**Yes**	**No**

DO YOU GIVE PERMISSION FOR THE SURGERY TO DISCUSS YOUR MEDICAL HISTORY, PAST AND PRESENT WITH THIS PERSON?

Condition for which you need a carer:		
Permission to discuss medical records:		
Is this person your main carer:		
Patients Signature:		
Print Name:		
Date:		

You can withdraw consent at any time by writing to the Practice Support Manager at Highlands Surgery, 1643 London Road, Leigh on Sea, Essex, SS9 2SQ.