ABBEY FAMILY PRACTICE
Bangor Health Centre
Newtownards Road
BANGOR BT20 4LD
Tel: 028 91 515300

Dr Deborah Simpson
Dr Jill Hutchinson
Dr Andrew Mottram
Dr Gillian Jackson

Patient Consent to Share Information with a Carer /Relative

PATIENT DETAILS	CARER / RELATIVE DETAILS
Name:	Name:
Address:	Address:
Post Code:	Post Code:
Telephone:	Telephone:
Mobile:	Mobile:
E-Mail:	E-Mail:
Date of Birth:	Relationship to patient:

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.

(Please detail below if the above access is to be limited in any way e.g. only for test results or only for making & cancelling appointments)

Specific exclusions are:

I understand that this consent will remain in force indefinitely. However, my doctor may, at my request, override this authority to allow access to my medical records at any time.

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

I will treat any information provided confidentially, I will not disclose information to a third party without agreement, and will only use the information in the best interests of the person that I care for.

Signed..... (Carer/relative)
Date.....

Please note evidence of identity will be required for both the patient and the carer/relative. Proof of identify includes copy of passport or driving license, and proof of address includes a copy of utility bill, medical card etc.

Please attach copies of the required documentation to this form