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**CONSENT FOR SPECIFIED PERSON TO HAVE ACCESS TO A PATIENT’S MEDICAL RECORD**

|  |  |
| --- | --- |
| Patient’s Name |  |
| Date of Birth |  |
| Patient’s Address |  |

To: St Austell Healthcare

I give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) to have access to

my medical records and personal details held by the Practice.

Their contact telephone number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This permission relates to (PLEASE TICK AS APPROPRIATE)

|  |  |
| --- | --- |
| All of my record |  |
| Part of my record |  |
| Specific condition |  |

Where the permission is restricted to part of the record only, or a specific condition, please specify below the precise limits of this permission, and any areas of the record which are excluded.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.**

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To be completed by SAH staff member:-*

*Name of patient’s photo ID Documentation seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date seen \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

*Staff Members Initials \_\_\_\_\_\_\_\_\_\_*

*If patient is housebound:-*

1. *Name of patient’s photo ID Documentation seen*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date seen \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

*Staff Members Initials \_\_\_\_\_\_\_\_\_\_*

1. *Name of person being granted access’s photo ID Documentation seen*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date seen \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

*Staff Members Initials \_\_\_\_\_\_\_\_\_\_*

1. *Phone call to patient to check permission is granted.*

*Date \_\_\_ / \_\_\_ / \_\_\_ Staff Members Initials \_\_\_\_\_\_*