SCHOPWICK SURGERY

To comply with the General Data Protection Regulations of 2018 with regards to patient records. Please complete the following to give your consent to discuss your medical information. This consent will be ongoing until you confirm to us, in writing, that you withdraw this permission:

Patients name: _____

Patients DOB: _____

Patients Signature: _____

Date: _____

I give my consent for:

Full Name and title: _____

Contact Number(s): _____

Address: _____

_____

DOB: _____

Relationship to patient: _____

Are they your Next of Kin? _____

Please tick the relevant boxes:

Full Medical Records ***[Includes all of the following]***	☐	Referrals	☐
Appointments	☐	Medication/Prescriptions	☐
Results	☐	Consultations	☐

RECEPTION – Please return back to REGISTRATIONS