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?

Permission to discuss medical records:		**Yes**	**No**
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.