KINGSWINFORD

Medical Practice

Consent to share information with a relative / carer

All our patients have a right to confidentiality. This means that we do not share information about you with anyone except those working for other health and social care organisations involved with your care.

However, you may wish other members of your family or close friends who might be involved in your care, to be able to talk to the staff about your care on your behalf. This can be particularly useful if you find it difficult to get to the GP surgery, communication is difficult for you or if that person helps to care for you.

This form will allow you to enable us to share information about your care with the person you specify in the form. We need both you and the person you would like us to share your information with to sign this form. **It is important that your relative / carer treats information about your care as confidential.**

You have the right to allow access to all or only part of your medical information. For instance if you have had previous medical problems you would prefer your relative or carer not to know about, you can specify this on the form. You can also override this consent to share information at a later date if you wish, for instance if you are currently undergoing treatment for a mental health condition requiring a carer to be involved and then your condition resolves.

If you have more than one person whom you wish to give permission for us to share information with, please fill out a separate form for each and return them to the Practice

Consent to share information with a relative / carer

Patient's details		**Relative's / Carer's details**	
Surname		Surname	
First Name(s)		First name(s)	
Date of Birth		Date of Birth	
Address		Address	
Post code		Post code	
Telephone		Telephone	
Mobile		Mobile	
E-mail		E-mail	

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I _____ give permission for my relative / carer to have access to my medical records and personal details held by the Practice and for staff to discuss this with my relative / carer.

This permission relates to all / part of my records. *(Please delete as appropriate)*

Where permission is restricted to part of the records only, the areas included are:
(e.g. only test results, only making and cancelling appointments)

_____

_____

Specific exclusions are:

_____

Patient:

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 _____

Relative / Carer:

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 person that I care for's best interest.

Signed_____(Relative / Carer) Date _____