**PATIENT THIRD-PARTY CONSENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients Name:** |  | | |
| **Patients Telephone Number:** |  | | |
| **Patients Address:** |  | | |
| I fully consent to Reservoir Road Surgery releasing my medical records including prescriptions to, the person named below.  This authority is for an indefinite period [ ] or for a limited period only [ ] *(tick one).*  Where a limited period applies, this authority is valid until …………………... *(Insert date).* | | | |
| **Third Party Name:** | |  | |
| **Third Party relationship to patient:** | |  | |
| **Third Party Telephone Number:** | |  | |
| **Third Party Address:** | |  | |
| Signed:  (Patient only) | | | Date: |

|  |  |
| --- | --- |
| **Reception / Admin Use Only** | |
| Coded with 9qA & annotated: |  |
| Added to Patient Home Screen: |  |
| Staff Initials: |  |
| Date Actioned: |  |
| Scheduled Task set up with removal date applied (if applicable: |  |
| **PLEASE NOW SCAN & COMPLETE** | |