**PATIENT THIRD-PARTY CONSENT**

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| --- | --- |
| **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** |