2 Irnham Road
Minehead
Somerset
TA24 5DL
Tel: 01643 703441
Email: somicb.mineheadmedicalcentre@nhs.net

MINEHEAD
MEDICAL CENTRE

CONSENT FOR RESULTS/INFORMATION TO BE GIVEN TO A THIRD PARTY

I……

of……

Date of Birth……

Give permission for any medical results to be given to:

……

Relationship to Patient……

of……

……Tel. No.……

and for my medical care to be discussed with him/her (Please delete)

PLEASE NOTE: A WITNESS MUST WITNESS THE PATIENT WHO IS GIVING THIRD PARTY CONSENT SIGN THIS DOCUMENT AND COMPLETE THE SECTION BELOW WITH THE PATIENT GIVING CONSENT PRESENT. PLEASE NOTE THE PERSON WHO IS BEING GRANTED THIRD PARTY PERMISSION CANNOT BE THE WITNESS FOR THIS AGREEMENT.

Name of Patient……

Signature of Patient……

Date signed……..

Name of Witness……

Signature of Witness……

Address of Witness……

……

Date Signed……

(Office use only: Return to SQ for authorisation & scanning)