GREENWOOD SURGERY

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Name: ____________________ Date of Birth: ____________________

Address: ____

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I hereby consent to the disclosure of my private medical information to:

Name: ____________________ Date of Birth: ____________________

Relationship: ____________________ Tel. No: ____________________

Address: ____

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Please circle the statement(s) that are applicable:

Full and open ended disclosure of any matter related to my medical record .... **YES / NO**

Full disclosure of any matter related to my medical record for the period .... **YES / NO**

(*From*): ____________________ (*To*): ____________________

Limited disclosure of the following aspects of my medical record:

- *Test Results*.. **YES / NO**
- *Prescription queries*.. **YES / NO**
- *Appointment queries*... **YES / NO**
- *Referral queries* .... **YES / NO**
- *Any other matter related to my medical record, please state:*

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____ **YES / NO**

I am aware that this consent may be revoked by me at any time.

Signature: ____________________ Date: ____________________

Witnessed by (not the individual for whom consent is being granted):

Name: ____________________ Signature: ____________________

Address: ____

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If you need assistance in completing this form please ask the Receptionist.