Bennfield Surgery

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Dr C J Warburton MB ChB MRCGP

Dr N J Doherty MB ChB MRCGP

Dr H C Barnes BMBS MRCGP

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Dr C Williams MBBS BSc MRCGP

Patient third-party consent

Patient's Name:	
Date of birth:	
Telephone number:	
Address:	

I consent to Bennfield Surgery granting the representative named below the ability to communicate with them about my medical records/information. I am fully aware that this will enable them to gain information about me and my medical problems, talk about my care, and give and receive information about me. This consent does not allow my representative to request copies of my medical records, sign any consent forms on my behalf, withdraw care or sign an order to prevent my resuscitation.

*(Please note that unforeseen **new** medical information during the period ticked below will also be shared unless you withdraw this consent)*

This consent is for:

☐ An indefinite period

☐ A limited period only, until …….. (please specify date)

Name of representative:	
Telephone number:	
Relationship to patient:	

Signed (patient only)…… Date:……