**JAMIESON MEDICAL PRACTICE**

CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION

If you wish us to speak to anyone else on your behalf about information we hold in your medical records we need your consent to be able to do this

Please complete the following permission form.

|  |  |
| --- | --- |
| **PATIENT DETAILS** | **CARER/ RELATIVE DETAILS** |
| **Name** | **Name** |
| **Date of Birth** | **Date of Birth** |
| **Address** | **Address** |
| **Postcode** | **Postcode** |
| **Contact Tele Number** | **Contact Tele Number** |
|  | **Relationship to patient** |
| **Date** | **Date** |

This permission relates to all/part of my records. (Please delete as appropriate)

Were permission relates to part of your records only, the areas to be included are

|  |  |
| --- | --- |
|  | YES NO |
| Appointments |  |
|  |  |
| Test Results |  |
| Sexually Transmitted Disease (STD) results & Treatment |  |
|  |  |
| Mental Health Diagnosis and treatment |  |
| Drug & Alcohol history & treatment |  |
| Pregnancy testing and prenatal care |  |
| Birth control/family planning |  |
|  |  |
| Medications |  |
|  |  |
| Hospital Correspondence |  |

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You have the right to withdraw this consent at anytime by contacting the practice and asking us to remove your consent to share information permission.**