**Consent to Share Confidential Information**

The Data Protection Act 2018 and the ethical codes of conduct of all health care professionals require that medical data be treated with great respect for confidentiality. We are not permitted to share any medical details with a third party without your consent.

**Patient details:**

|  |  |
| --- | --- |
| Patient Name: |  |
| Date of Birth:  |  |
| NHS Number:  |  |

**Person I am giving consent to:**

|  |  |
| --- | --- |
| Full Name: |   |
| Date of Birth:  |   |
| Telephone Number: |  |
| Relationship to patient: |   |
| Are you a patient at Bedwell Medical Centre/Roebuck Surgery? | Yes [ ]  No [ ]  |

**Please tell us if this consent is permanent or temporary:**

|  |  |
| --- | --- |
| Permanent [ ]  | Temporary [ ]  Start Date: End Date: |

I give consent to the sharing of my medical information with the above person, this permission relates to all parts of my medical record.

I understand it is my responsibility to inform Bedwell Medical Centre/Roebuck Surgery if I change my mind and wish to remove consent to share my medical information with the above person. I am aware if I wish to retract this consent, I must notify the practice in writing.

 **Patient Signature** …………………………………………………………….

 **Date**  …………………………………………………………….