**Patient Consent to Release of Health Information**

**Patient’s Name …………………………………………………….**

**Date of Birth ……………………………………………………….**

**First line of address………………………………………………..**

**I hereby give my consent for the release of:**

**Any health-related information\*/ Appointment information only\*/ Test results only\* (\*please delete as appropriate) to the following person**

**Name …………………………………………………….**

**Date of Birth ……………………………………………………….**

**First line of address………………………………………………..**

**Relationship to Patient: …………………………………**

**(for example: husband, wife, son, daughter, carer, neighbour)**

**I give my consent for the above to discuss, provide and receive information in respect of my medical records as indicated above. I understand I am required to advise the surgery should my wishes change and this consent will remain in force until I advise the surgery otherwise.**

**Signed ………………………………………………………………………**

**Date………………………………..**

**For Practice Administration Staff**

Reminder added to home screen; relationship recorded …………….

Scanned…………………….