**Consent to Share**

**Information with Relative/Carer**

|  |  |
| --- | --- |
| **PATIENT DETAILS** | **RELATIVE/CARER DETAILS** |
| Name |  | Name |  |
| Address |  | Address |  |
|  |  |  |  |
|  |  |  |  |
| Post Code |  | Post Code |  |
| Telephone |  | Telephone |  |
| Email |  | Email |  |
| Mobile |  | Mobile |  |
| Date of Birth |  | Relationship to patient |  |

I hereby give permission for my relative/carer named above to have access to all my medical records and all personal details held by the Practice.

I also consent to staff discussing any matters regarding my medical records and personal history with my relative/carer.

Signed ……………………………………………………………………………………………… (Patient)

Date …………………………………………………………………………………………………