LITCHDON MEDICAL CENTRE

Allowing Others to Speak on Your Behalf and Sharing Information

SECTION 1

Please complete this form if you wish to grant a representative the ability to communicate with us about you. This will enable them to gain information about you and your medical problems, talk to us about your care, and give and receive information about you. It will not entitle them to order copies of your medical records, sign consent on your behalf, withdraw care or sign an order to prevent your resuscitation. Giving consent to someone else to communicate with us about you and your medical problems is a very significant step and you should give it serious consideration before you give consent. You need to consider what they might learn about you and your problems that you did not want them to know and have fully considered the ramifications of giving that consent. Once they learn information about you, they might also share it with others that you did not intend to have that information. If you are unsure about giving consent, we advise that you do not give it and that you seek legal advice before proceeding. If a patient has an active Lasting Power of Attorney document (Health & Welfare certificate) this can be submitted instead of this form.

A member of the practice team may speak to the patient once the form is returned to verify this request if the patient does not attend with the third party on returning the form to the practice.

Please note – Only one representative can be named one each form. Additional forms can be completed if necessary.

SECTION 2 – PATIENT DETAILS

SURNAME	
FIRST NAME	
FULL ADDRESS	
DATE OF BIRTH	
PHONE NUMBER	

SECTION 3 – REPRESENTATIVE(S) DETAILS

SURNAME	
FIRST NAME	
FULL ADDRESS	
DATE OF BIRTH	
PHONE NUMBER	
RELATIONSHIP TO PATIENT	

SECTION 4 – TYPE OF CONSENT. IF YOU WISH TO REMOVE OR ALTER THE CONSENT, PLEASE CONTACT THE SURGERY DIRECTLY.

ALL DETAILS OF APPOINTMENTS ONLY	YES / NO
ALL INFORMATION WITHIN MEDICAL RECORDS	YES / NO

SECTION 5 - PATIENT'S SIGNATURE**. I have read the form fully and consent to the release of confidential information to the person as stated in section 3 & 4.**

PATIENT'S SIGNATURE	
DATE OF SIGNING	

PLEASE NOTE: This form must be completed and signed by the patient giving the permission for access to their medical record. Any incorrectly completed forms will not be processed.

Please return original forms to the practice, scanned copies cannot be accepted.

LMC STAFF USE ONLY:

DATE RECEIVED & STAFF INITIALS	
SCAN TO MEDICAL RECORDS	
ADD HIGH PRIORITY REMINDER TO HOME SCREEN. ADD DATE & INITIALS	
PATIENT CONTACTED TO CONFIRM DETAILS VERBALLY?	YES / NO