TOWNSEND HOUSE SURGERY PATIENT CONSENT FORM

Please note this form must be signed by the patient and enables the Practice to release information, ie , test results etc to the nominated person(s) below

PATIENT'S DETAILS

Surname: ……

First Names: ……

Date of Birth: …… Male/Female: ……

Address……

……

I consent that disclosure of information relating to my medical care is released to:

PLEASE RECORD BELOW THE DETAILS OF THE PERSON (S) YOU WISH INFORMATION TO BE RELEASED TO

Full Name ……

Relationship to Patient ……

Address (if not the same as patient):
……

……

Contact details: ……

If there are to be any restrictions on release of information please list these below.

Signature of Patient: ……

Date: ……

Restrictions:
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