Patient Consent Form for another person to access their medical record. (Including parents requesting proxy access for children)

Patient's Details (The person giving access)	
Surname	
First Names	
Date of Birth	
Address	
Telephone Number	
Details of person accessing this patient's information (requestor)	
First Name	
Last Name	
Date of Birth	
Address	
Telephone Number	
Relationship to patient.	

Details of access to be granted.

Face to Face and Telephone Contact	
(tick all appropriate)	
Appointment booking	
Test results	
Prescription ordering and queries.	
Full medical record access.	

Medical Record Access (proxy)	
(tick all appropriate)	
Appointment booking	
Prescription Management	
Full medical record access	

Duration of consent. (F2F & telephone)	
(tick appropriate)	
Until (specify date)	
Full year	

Duration of consent. (medical record)	
(tick appropriate)	
Until (specify date)	
Full year	

I understand fully the implications of this regarding my confidential medical information and understand that it is my responsibility to renew this consent yearly or remove my consent if my wishes change.

My consent is relating to information held by the NTC Community Clinic only, and no other organization.

Signed: ……………………………………………………… DATE: ……………………………………

Practice use only.

Patient ID Seen? ☐ Requestor ID Seen if applicable? ☐

ID Verified - Staff member name: …………………………… Patient number………………………………