

Oldwood Surgery & Battle Health Centre

APPLICATION FOR THIRD-PARTY ACCESS TO HEALTHCARE INFORMATION patient with capacity

To maintain confidence in our patients, at Oldwood Surgery & Battle Health Centre we will not divulge any medical information about you unless it is legally appropriate, or we have your consent to do so.

Who should complete this form?

Anyone who is competent to do so. It is difficult to state at what age any child will become competent to make autonomous decisions regarding their healthcare as between the ages of 11 and 16 this varies from person to person. As most children are content that their parents have access to their healthcare information, this form will ordinarily be used for adults. However it may equally be used for a child whom it is considered has capacity and can understand their actions.

Agreement

Should you wish to consent for a nominated person to be able to discuss any medical information about you with staff at this practice, please indicate this on the form below.

By completing this form, the following should be noted:

- The person granting access to a third-party must fully complete and sign the form
- Any incorrectly completed forms will not be processed and will be returned to person making the application
- This form does not permit any third-party individual to make healthcare decisions on behalf of the named patient
- This practice may contact you via email or telephone should there be any concern

Disclaimer: It is your responsibility to keep us informed as to who can access and discuss specific areas of your medical record as detailed on the form. Should your circumstances change, it is your responsibility to advise the practice. Oldwood Surgery & Battle Health Centre relinquish all responsibility should the above information become incorrect if not updated.

I, _____ hereby give permission for Oldwood Surgery & Battle Health Centre to discuss my medical records with the following:

Patient requesting permission to allow third party access	
Full name	
Date of birth	
Address	

Signature		
Date		
Telephone/Email		
Named person receiving access		
Full name		
Address		
Relationship		

Agreement as to what can be divulged

I give permission for the following to be permitted or discussed with the above named person should they request (tick all that apply):

Appointments	Medication	Consultations	Test results	Referrals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>