

Oldwood Surgery & Battle Health Centre

APPLICATION FOR THIRD-PARTY ACCESS TO HEALTHCARE INFORMATION patient without capacity

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

Who should complete this form?

Anyone who has authority, such as a lasting power of attorney (LPA), may lawfully act on behalf a patient who does not have capacity. Prior to any release of information, the identity of the nominated person will be established and the [Office of the Public Guardian](#) will confirm that the nominated person is acting as an LPA for the named patient.

Agreement

It is confirmed that a nominated person has an agreement, such as an LPA, to act on behalf of a patient who no longer has capacity.

There is a need to have the below named patient's medical information released to another third party, e.g., a care home. The nominated person may act on behalf of a patient and request that their medical information is provided.

By completing this form, the following should be noted:

- The nominated person will be acting in the best interest of the patient
- The form must be fully completed and signed
- Any incorrectly completed forms will not be processed and will be returned to person making the application
- This form does not permit any nominated individual to make healthcare decisions on behalf of the named patient
- This organisation may contact the nominated person via email or telephone should there be any concern
- This form must be completed each time a new request to release information to a third party is required

It is the responsibility of the nominated person to keep the organisation informed as to who can access and discuss specific areas of the named patient's medical record as detailed on the form. Should any circumstances change, it is the responsibility of the nominated person to advise this practice.

I, _____[nominated person], hereby give permission for this organisation to discuss clinical information about the medical records of _____[patient name] as follows:

Name of patient	
Full name	
Date of birth	
Address	

Nominated person requesting permission to allow third-party access

Full name		
Relationship		
Address		
Signature		
Date		
Telephone/email		

Named organisation receiving access

Name		
Address		
Requirement		

Agreement as to what can be divulged

I give permission for the following to be divulged or discussed with the above named organisation 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"/>

For office use only:

Identification verification must be verified through 2 forms of ID

- One of which must contain a photo, e.g., passport or photo driving licence, and a bank statement
- When this is not available, vouching by a member of staff or by confirmation of information in the records by one of the clinicians may be used
- LPA verification must be conducted through the [Office of Public Guardian](#)

Request received		Request refused	
Reviewed by		Request completed	

Date sent			
Comments			
ID verified by		Date	
Method	<input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Vouching – by whom <input type="checkbox"/> Vouching with information in record – by whom		
LPA verified by		Date	
Comments			