BLAKE HOUSE SURGERY
PATIENT CONSENT FORM

Patient's Details	
SURNAME	
FIRST NAME(S)	
DATE OF BIRTH	
MALE/FEMALE	
ADDRESS	
CONTACT NUMBER	

Details of the person(s) to be given access to this patient's information

What the patient would like to share, please tick the individual columns required for each consented person.

	Making and cancelling appointments	Picking up scripts/medication	Finding out test results	Unlimited consent
1-Full Name				
1-Address				
2-Full Name				
2-Address				
3-Full Name				
3-Address				
4-Full Name				
4-Address				

I confirm that I give permission for the practice with the person identified above in regards to acting on my behalf regarding the selected medical issues.

Signature	
Date	

NB: You may withdraw/change this at anytime