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GRANGE MEDICAL GROUP

DATA PROTECTION ACT
THIRD PARTY ACCESS TO MEDICAL RECORDS

In accordance with the above act the Practice requires your consent before we can give out any information regarding yourself to a third party. I would be grateful if you would complete this form giving me details of whom you wish any results, prescriptions, or any other aspects of your medical records given out to.

I appreciate your help in this matter.

Thank you

Elaine Weir
Practice Manager

I (Print Name) _____

Date of Birth _____

Authorise the person named below to obtain results, prescriptions or anything relating to my health from the Grange Medical Group.

Signature _____

Date _____

Authorised Person (Print Name) _____

Relationship to Patient _____

Address of Authorised Person _____

_____

Telephone Number _____

This form will be kept in the front of your medical records.