**Consent Form**

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| --- | --- |
| **Patient Name** |  |
| **Patient Address** |  |
| **Patient D.O.B.** |  |
| **Patient Contact Telephone Number(s)** |  |

I give permission for the person named below to speak to the staff at **The Avenues Medical Centre** on my behalf **until I advise you otherwise** **or until** (enter an end date)…………………….

Please be aware that this consent form is not a legally binding document and we would advise that appropriate steps are taken by you if there are any concerns raised regarding the capacity of the individual that this consent form relates to. You can find information regarding Lasting Power of Attorney on the direct.gov website

<https://www.gov.uk/power-of-attorney> or be attending a local Citizens Advice bureau

Please tick in the boxes to indicate below specific consent to be given.

|  |  |
| --- | --- |
| **Medication/Prescriptions** |  |
| **Appointments** |  |
| **Results** |  |
| **Referrals** |  |
| **All Health Care Needs** |  |
| **Other – Please state** |  |

 If there are any areas of your medical records that you **DO NOT** wish us to discuss with the person named below please indicate these in the box below.

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|  |  |
| --- | --- |
| **Name** |  |
| **Relationship to Patient** |  |
| **Contact Telephone Number(s)** |  |
| **Registered carer** | **Yes/No** |

Would you like the above named person to be added to your medical records as your registered carer? If so please indicate above.

|  |
| --- |
| **Any other information you feel would help us in caring for you, i.e. key safe number** |

Patient signature ………………………………………….. Date ……………………………

**------------------------------------------------------------------------------------------------------------------------------------------------------**

**PRACTICE STAFF USE ONLY**

Patients ID seen? Passport □

 Driving Licence □

 Other □

Completed & signed on site? YES/NO (please delete as applicable)

**ADMIN/PRACTICE MANAGER USE ONLY**

If NO – has other verification process been completed? YES/NO

Details: