**The Avenues Medical Centre**

Consent Form

|  |  |
| --- | --- |
| 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 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.

|  |
| --- |
|  |

|  |  |
| --- | --- |
| 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 …………………………