QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

FOR OFFICE USE ONLY

To be completed when clinical system updated

Staff Initials: _____

Date: _____

Family/Friends Disclosure of Information Consent Form

Patient Details	
Patient's Full Name:	
Date of Birth:	
Address:	

I give consent for the Doctors and Staff of Queens Road Medical Practice to disclose and discuss with the person named below (please delete any part not applicable):

- ☐ personal information regarding my healthcare (including past medical history, current health conditions, investigations and treatments or anything relating to them)
- ☐ my account (for billing purposes)

Name:	
Contact details: Telephone/Email	
Relationship to patient:	
Date of birth:	

I understand that I can withdraw this consent at any time and that it will remain in place until such time that I advise in writing to the contrary.

Signature of patient:	
Date:	

A copy of the patient's photographic identification that includes a signature needs to accompany this request unless completed in surgery and witnessed by a member of staff

Photographic identification provided:	YES / NO (if NO, please pass to member of staff for signing below)
Witnessed by (staff name and signature):	
Date:	

Please pass to Document Management - scan into patient notes, alert added to Evolution and Medibooks