

Agreement by a Patient to allow a Carer to have access to their Personal Details and / or Copies of Correspondence.

Patient's Name	
Patient's Address & Post Code	

To: Liphook & Liss Surgery

I give permission for my Carer, _____ to have access to my personal details and medical records held by the Practice.

Delete those which are NOT applicable:

<i>This permission relates to all my records.</i>	
<i>The permission relates to part of my records.</i>	
Please specify the parts of the record to which access is allowed and any areas which are specifically excluded.	
<i>This permission relates to a specific condition.</i>	
Please specify the condition.	
<i>The permission relates to my Carer receiving copies of all correspondence relating to my treatment.</i>	
I confirm that my GP has explained this to me and has sole discretion to withhold any or all copies.	

I understand that this permission will remain in force until cancelled by me in writing and that the doctor may override this authority at any time.

I consent to my Carer receiving copies of all correspondence relating to my treatment (delete if not applicable). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed Patient: _____ Date: _____

Accepted by Doctor: _____ Date: _____