SELBORNE ROAD MEDICAL CENTRE
DR LISA MORRIS ◆ DR ROSALIE KNOWLES

Patient consent form

Patient details:

Surname:			
First name:		DoB:	/ /
Address:			
Telephone number:		Mobile number:	

I wish for the individual(s) listed below to be able to discuss and action certain aspects of my medical record. These include:

To discuss any information from my full medical record (this covers all the other options below)	☐
Booking/discussing appointments	☐
Ordering/discussing prescriptions	☐
Discussing results	☐
Requesting/discussing referrals	☐

Individual(s) patient gives consent to:

Name(s)	Relationship to patient
.	
.	
.	
.	

Signature of patient:

Signature:		Date:	

For practice use only

Method patient contacted to confirm consent:	☐ In person ☐ Vouching	Phone call ☐ Other (specify in SystmOne Journal) ☐

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