The Westgate Practice

AUTHORITY TO SHARE MEDICAL INFORMATION

This form records who the practice may discuss your health and care with. It does not give that person authority to make decisions for you or allow them direct access to your medical record. You can change or withdraw your permission at any time.

1. Patient details

Full name: _____ Date of birth: _____
Address / postcode: _____ NHS no. (if known): _____

2. Person(s) I authorise the practice to speak to

Name: _____ Relationship to me: _____
Telephone: _____ Email (optional): _____

Name: _____ Relationship to me: _____
Telephone: _____ Email (optional): _____

I give the practice permission to:
□ Discuss information relevant to my health and care with the person(s) named above, including diagnoses, medication, investigations/results, referrals and care plans.

□ Discuss only the following health issue(s) / information:
_____
_____

Duration of this permission: □ Until I withdraw it □ Until ____ / ____ / _____
N.B. It is your responsibility to contact us if you wish to change your decision and the practice may also use their judgement about whether your decision or capacity may have changed

3. Patient declaration

I understand what I am authorising and agree that the practice may share the information described above. The practice will still use professional judgement and share only information that is appropriate and relevant. I understand that I may amend or withdraw this permission at any time.

Patient signature: _____ Date: _____
If completed with staff: name: _____ Role: _____

N.B. A relative or carer may give information to the practice even if the patient has not authorised disclosure back to them. Information supplied may become part of the medical record and may later be visible to the patient.