MAIRCHES
MEDICAL PRACTICE - HAWICK - GALASHIELS

Third Party Consent Form

Completing this form grants a named representative the ability to communicate with the Practice on your behalf; allowing the named representative access to information about you and your medical record, an ability to talk to us about your care and give/receive information about you.

Giving consent for someone else to communicate with us about you and your medical health conditions is a significant step and should be given serious consideration.

By completing this form you are advising that you have fully considered the ramifications of giving that consent to a third party. If you are unsure about giving consent we advise that you seek further, appropriate advice before proceeding. This consent form authorises a named individual to access and discuss your medical record until you tell us otherwise.

I am a patient of Mairches Medical Practice and understand that I have chosen to give consent for a third party to have access to my medical records and the ability to discuss my medical requirements with the Practice. I understand that the contact details of the nominated individual will be recorded in my medical record. I confirm that I have obtained the consent of my nominated individual to share their contact details with the Practice.

I understand that if I wish to remove consent I have the right to contact the surgery to revoke consent at any time.

DETAILS OF PATIENT

Surname:	Forename(s):
Date of Birth:	Tel. Number:
Address:	
Email	Postcode:

DETAILS OF AUTHORISDED PERSON

Surname:	Forename(s):
Date of Birth:	Tel. Number:
Address:	
Email	Postcode:
Relationship to Patient:	

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I understand that, by signing this form I authorise the above named person to*:

- **Ask details about my appointments and also make / change appointments on my behalf.**
- **Discuss my medication, and order /collect prescriptions on my behalf.**
- **Obtain test results and immunisation information.**
- **Discuss referrals that may have been made on my behalf.**
- **Discuss my medical record, be informed of any diagnosis and discuss my whole medical history.**
- **Complain on my behalf and receive a response.**

**This list is not exhaustive.*

I have a right to withdraw this authorisation, in writing, at any time and I am signing this authorisation voluntarily.

SIGNED BY PATIENT	**DATE:**
SIGNED BY AUTHORISED PERSON:	**DATE:**