**Bradford on Avon & Melksham Health Partnership**

**Consent To Access Medical Records**

**I (NAME)** ………………………………

**Date of birth:** ………………………………

**Address:** ………………………………

 ………………………………

 ……………………………… ………………………………

**Day time telephone number:** ………………………………

**Mobile telephone number:** ………………………………

hereby give permission for the undersigned to be given the following information from my medical records

Relationship *(i.e Mother, Brother, Husband, etc)* ………………………………

Miss/Ms/Mrs/Mr ………………………………

Date of Birth: ………………………………

Address: ………………………………

 ………………………………

 ………………………………

**Tick appropriate box/s:**

 **Tick**

|  |  |
| --- | --- |
| All test results |  |
| All appointments |  |
| All letters and referral information |  |
| OR Full access to my entire medical record |  |

**If I would like to discontinue or amend consent given, it will be my responsibility to inform the Practice.**

Signed …………………………………………….. Date ………………………….

 **(Patient)**

**For office use only** (Initials please)

Consent form received by: ……………………………. Date …………………

Consent entered onto patient home screen by ……… Date …………………

Daytime phone number up-dated if different ………… Date …………………

Consent form scanned onto patients record by …….. Date …………………

Revised 19.04.13/DH