Castle Medical Group

Patient Consent Form

Due to patient confidentiality, we cannot discuss a patients record without express consent, unless you are the parent/ guardian of children under 11 years old.

To authorise someone else to discuss your medical records with us, please complete this form and ensure it is signed by you, the patient, and presented to our practice staff in person with ID, or else it will not be processed.

The permission will be granted for one year, and a new form will have to be submitted thereafter. The patient can revoke consent at any time by contacting the practice.

Should your circumstances change; it is the patients' responsibility to update us regarding who can access and discuss their medical record. Castle Medical Group bears no responsibility for any subsequent consequences should these details not be kept up to date.

Patient name: _____ **Date of birth:** _____

I hereby give permission for Castle Medical Group to discuss the below (ticked) with the following people, unless stated otherwise:

Name	Date of birth	Relationship to patient	Contact number	Registered at this surgery?

Appointments	☐
Prescriptions	☐
Test results	☐
Consultations with the Doctor / Nurse	☐
Referrals	☐
Solicitor matters	☐
Insurance matters	☐

Patients signature: _____ **Date:** _____

For office use only

ID Provided: