DR Khans Practice

CLAYTON HEALTH CENTRE

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

(If you need assistance in completing this form, please inform the Receptionists)

Patient details:

Name: ______________________ Date of Birth: ______________

Address: ____

____

I hereby consent to the disclosure of my private medical information to:

Name: ______________________ Date of Birth: ______________

Relationship: ______________________ Tel No: ______________

Address: ____

____

Please tick the statement(s) applicable:

☐ *Full and open ended disclosure of any confidential information from my medical record*

☐ *Full disclosure of any confidential information from my medical record for the following period:*

Date from: ______________ *to:* ______________

☐ *Limited disclosure of only the following confidential information:*

____

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Signature: ______________________ Date: ______________

Witnessed by member of staff (name): ______________ Date: ______________

I am aware that my consent may be withdrawn at any time, by submitting my written request to the Practice Manager.