COBBS GARDEN SURGERY

CARER'S MEDICAL RECORD ACCESS FORM

By completing this form, the patient gives consent for their Carer to access their Medical Records and information relating to their care.

Patient's Name	
Patient's D.O.B.	
Patient's Address	

To: Cobbs Garden Surgery

I give permission for my Carer [insert carer name]_____ to have access to my medical records and personal details held by the Practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded.

_____
_____
_____

I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

Signed _____ (Patient)

Date _____

Accepted by _____ (Doctor)

Date _____