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**CONSENT LETTER TO DISCLOSE INFORMATION**

**Please complete this form if you wish for somebody other than yourself to have access to your medical records, this could include your medications, referrals, or consultation notes.**

I confirm that I consent to my doctor or other staff members disclosing details of my medical records where appropriate to:

**Name: ………………………………………………………………………**

**Address: ………………………………………………………………………**

 **………………………………………………………………………**

 **………………………………………………………………………**

 **………………………………………………………………………**

**Telephone Number: …………………………………………..**

**Patient Name: ………………………………………………………………………**

**Patient Address: ………………………………………………………………………**

 **………………………………………………………………………**

 **………………………………………………………………………**

 **………………………………………………………………………**

**Patient D.O.B: ………………………………………………………………………**

**Patient Signature: ………………………………………………………………………**

**Date: ……………………………**

***I understand that it is my responsibility to let the surgery know of any changes to this consent.***