THE WallHouse SURGERY
Personal • Proactive • Preventative

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Patient Consent Form
Access to their Medical record by a third party

PATIENT DETAILS The person whose records another individual is to be given access to	
Full Name:	
Date of Birth:	
NHS Number (if known)	
Do you use the NHS App	

PROXY ACCESS The person to be given access to this patients information	
Full Name:	
Date of Birth:	
Relationship to Patient	
Are they a patient at this practice?	
If yes, and if you use the NHS app, would you like this person set as a proxy user in your NHS App Account . This means that they will have full access to my medical record.	
Full Address:	
Contact Number:	
Email:	

In order that we may grant the correct level of access to your representative. Please complete the below.

I give my permission for my representative named above the following:

Please only tick ***ONE BOX*** *IF YOU TICK MORE THAN ONE BOX THEN YOUR FORM WILL BE DESTROYED.*

They can contact the practice on my behalf via telephone, sms, email or in person to FULLY discuss my medical record BUT I would still like MY contact number to be the main point of contact and to contact and speak to me in the first instance		OR	They can contact the practice on my behalf via telephone, sms, email or in person to FULLY discuss my medical record. I would prefer you to add my representatives contact number to record and to contact THEM FIRSAT for all matters relating to my health	

If you ***DO NOT*** want your representative to have full access to your medical records ***THEN*** complete below. If you have ticked one fo the boxes above DO NOT tick one of the following as this will invalidate your form and it will be destroyed. If neither apply below please leave ***BLANK*** . You can tick both of the below if they apply.

My representative can ONLY call and make appointments, cancel them or move them on behalf. They can NOT have access to my medical records.		OR	My representative can call or collect test results whther via telephone, SMS, email or in person ONLY. I am aware that this may mean that some information about my health may need to be discussed and I am happy with this.	

UNLESS specified otherwise, the above will not change unless consent is withdrawn. If you would rather add an end date please do so below:

I can confirm as the patient that I have completed this form of my own volition and without pressure.

Signed:	
Date:	