Milton House Surgery, Berkhamsted

Patient Confidentiality Consent Form

I, ____

Date of Birth: ______________________________

Address: ___________________________________

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Postcode: __________________________________

give consent for Milton House Surgery to discuss with

Name: _____________________________________

Date of Birth: ______________________________

Address: ___________________________________

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Postcode: __________________________________

This person's Relationship to me: __________________________

the following aspects of my medical care records:

Cancel/Amend appointments……………………………… **YES/NO**

Discuss results on the telephone/face to face……… **YES/NO**

Receive messages from the surgery……………………… **YES/NO**

Discuss all health information……………………………… **YES/NO**

Collect prescriptions on my behalf……………………… **YES/NO**

Order Prescriptions on my behalf……………………… **YES/NO**

Signature: __________________________________

Date: ______________________________________

For internal use:

Code XaNwR added ☐

Date added …………………………….