BILLINGHAY MEDICAL PRACTICE

CONSENT TO ACCESS MEDICAL RECORDS

To Reception
Billinghay Medical Practice
39 High Street
Billinghay
Lincoln
LN4 4AU

Patient Name ______________________________

Patient NHS Number ______________________________

(please contact the surgery if you are unsure of this)

Patient Date of Birth ______________________________

Patient Address ______________________________

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I hereby give consent for Billinghay Medical Practice to release the following information to:

Name of Authorised Individual ____________________________

Relationship to Patient ____________________________

Password ____________________________

(please advise the authorised individual of your chosen password as medical information will only be disclosed to your authorised individual on correct disclosure of the chosen password. Passwords can only be reset by the patient and we will note your password on our computer system).

I consent to disclosure of the following information (please tick all that are appropriate):

☐ All medical information (including that of a sensitive nature and below categories)

☐ All medical information (excluding that of a sensitive nature but including below categories)

☐ Blood test results only

☐ Medication Information

☐ Results of investigations (e.g. blood tests, x-rays, hospital referrals)

Please note this consent will be held on your medical record until such time as you ask us to remove it. Please remember to notify us if your circumstances change.

Signed ________________________

Dated ________________________

Partners Dr KC Leeper & Dr H Passfield