

Croyard Medical Practice – Medical Consent

Consent for a representative to discuss and access medical records on your behalf

Patient Name **Date of Birth**

Address

.....

.....

Post Code

Name of Representative

Contact Number

Relationship to Patient

Do they hold Power of Attorney? Y/N (Circle as Appropriate)

Declaration of Consent

I hereby given consent for the above-named representative to discuss **All** my medical records on my behalf, including but not limited to Test Results, Appointments and Medical History.

I Understand that I can revoke this authority at any time by contacting Croyard Medical Practice.

Signed

Date