Marsh Medical Practice

Consent to Share Medical Records

This form should be used for patients to consent to their medicals records being shared with a medical professional/clinic for the purpose of completing a medical report e.g. adoption, fostering, driving, pilots or firearms license)

Please complete fully to avoid delays

I (*patient name*)……Date of Birth:……..

Address: ……

……..

give consent for Marsh Medical Practice share all my primary care medical records with:

Name: ……

Organisation: ……

Address: ……

……

Telephone Number: ……

Secure Email (e.g. NHS.net) :……

I understand that this will include copies of ALL medical records and letters that Marsh Medical Practice hold and may include sensitive and confidential information.
Any information will be sent directly to the clinician/organisation completing the medical report.

Signature* ……..Date: ……..

Name and relationship to patient if not signed by patient ……

*to be signed by person with parental responsibility if the patient is a child
*to be signed by person with POA if patient lacks capacity – please provide copy of POA