STEYNING HEALTH CENTRE

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Permission to disclose data

In accordance with the Data Protection Act, the practice is not permitted to give any information about a patient to any third party unless we have the patient's written permission.

On signing this form, please note that you are giving consent for us to tell the named person about past medical problems as well as current or future conditions. If there are any medical conditions or any part of your medical records that you do not wish the person named below to be told about, then you must notify us. The arrangement will continue until you notify us otherwise, in writing.

My name: ……………………………………………………………………………….

My date of birth: ……………………………………………………………………..

My address: ……………………………………………………………………………..

………………………………………………………………………………………….

I hereby give permission for Steyning Health Centre to discuss information to the following named person:

Name of person: ……………………………………………………………………….

Address: ………………………………………………………………………………

Telephone/mobile number(s): ………………………………………………………...

Signature of patient: ………………………………………………………………….

Date: …………………………………………………………………………………