**GREENGATE MEDICAL CENTRE**

**Consent to discuss medical details**

Please complete this form if you are giving consent for a relative, friend or neighbour to contact the surgery on your behalf to discuss details regarding your health, for example, test results, appointments etc.

**Patient details:**

Title (Mr, Mrs, Ms)…………………………….Surname…………………………………………………………..

First Name ………………………………………. Date of Birth …………………………………………………….

Address ……………………………………………………………………………………………………………………….

Postcode …………………………………………. Day Time Number…………………………………………….

Evening Number………………………………. Mobile Number………………………………………………..

Email address ………………………………………………………………………………………………………………

Name of GP …………………………………….…………………………………………………………………………..

Patient Signature ………………………………………………………………Date …………………………………

I confirm that I give consent for the person named below to contact the surgery on my behalf to collect test results, and also to discuss details regarding my health.

**Consent given to:**

Title (Mr, Mrs, Ms)……………………………. Surname ………………………………………………………..

First Name ……………………………………….. Date of Birth ………………………………………………….

Address………………………………………………………………………………………………………………………

Postcode……………………………………….. Day Time Number…………………………………………..

Evening Number……………………………… Mobile Number ……………………………………………..

Relationship to the person giving consent: Partner/Relative/Friend/Neighbour

Signature………………………………………………………..(**Of person who is being given consent**)

Date ……………………………………………………