PATIENT CONSENT TO SHARE RESTRICTED ACCESS

Patients Details (The person whose records another individual is to be granted access)	
Surname	
First Name	
Date of Birth	
NHS Number	
Gender	
Address Postcode	
Contact Telephone Number	
Details of the person who will have restricted access	
Full Name	
Address Postcode	
Contact Telephone Number	

Please Note: Identification will need to be provided by the patient upon application. Sleaford Medical Group must be able to verify consent and signature from the patient.

Give consent to the person named above to act on my behalf for: (Please Tick)	**YES**	**NO**
Collect Blood/Urine/X-Ray Request Forms & Results	☐	☐
Collect Sick Notes	☐	☐
Collect Prescriptions from Reception	☐	☐
Discuss my continuing medical care with my GP	☐	☐

Signed: _____ Dated: _____

!! ID Check_____

This will remain on your records unless you notify the surgery that you wish for it to be removed.

Rec Ints		Date	

When completed please post this form or hand it in to: Sleaford Medical Group, 47 Boston Road, Sleaford, NG34 7HD

OR

Submit via the practice website: www.sleafordmedicalgroup.co.uk/medical-forms