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CHELSTON HALL

Branch Surgery at Barton

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Confidentiality and information sharing Consent Form

I _____ (full name)

Date of Birth _____ NHS Number_____

Give consent for Chelston Hall Surgery to share information with:

Full Name: _____

Date of Birth: _____

Relation to you (for example mother, brother, carer): _____

Address: _____

Phone number: _____

About the following aspects about my care and treatment:

Current and future diagnosis and symptoms	YES / NO	
My medication (dose and how it is taken)	YES / NO	
Test results	YES / NO	
My care plans	YES / NO	
My past medical history (please state if from birth or a specific date)	YES / NO	Dated from:
Clinic letters (please state if from birth or a specific date)	YES/NO	Dated from:
Other (Please specify)		

☐ I am aware that this consent is valid until I notify Chelston Hall Surgery otherwise and it is my responsibility to do this should my circumstances change.

Signed _____Date _____