**Permission to Share Limited Health**

**Information Form**

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| **Patient’s details** |
| **Surname** |  |
| **First name** |  |
| **Date of birth** |  |
| **Male/female** |  |
| **Address** |  |
| **Telephone number** |  |

By signing this form below, I give permission for the person listed below to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friend in order to assist with my continuing care.

Any information requested that does not pertain to assisting with my healthcare and any requests for copies of medical records will require a signed compliant authorisation or an appropriate Power of Attorney.

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| **Detail of person to be given access to this patient’s information** |
| **Full name** |  |
| **Address** |  |
| **Telephone number** |  |
| **Relationship** |  |

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| **Please indicate below the area(s) of data sharing**  |
| 🞏 Discussion of consultations | 🞏 Access to letters for collection |
| 🞏 Collection of medications | 🞏 Collection of prescriptions |
| 🞏 Making and cancelling of appointments |  |
| 🞏 Other (please specify) |

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| **Access period** |
| 🞏 For one month | 🞏 For six months |
| 🞏 For twelve months | 🞏 Indefinitely |

This permission duration can be amended at any time by the patient contacting the practice directly.

To obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

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| **Your chosen identifier/password** |  |

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| **I confirm that I give permission for the practice to communicate with the person identified above regarding my medical records** |
| **Signature** |  |
| **Date** |  |