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PERMISSION TO DISCLOSE DATA

In accordance with the data protection act, the practice is not permitted to give information about a patient to a third party unless we have the patient's written permission.

On signing this form, please note that you have given consent for us to tell the named person(s) about past medical problems as well as current medical and future conditions. If there are any medical conditions 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.

My Name _____

My Date of Birth _____

My Address _____

I hereby give permission for Henfield Medical Centre to discuss information with the person(s) named below;

Name of Person _____

Address _____

Relationship to me _____

Contact Phone Number(s) _____

Signature of Patient _____ Date _____