ST. ANDREW'S MEDICAL CENTRE

AGREEMENT FOR A CARER TO HAVE ACCESS TO A PATIENT'S PERSONAL DETAILS and/or COPIES OF CORRESPONDENCE

Patient's Name	
Patient's Address	

To: *St Andrews Medical Centre*
I give permission for my carer [ ] to have access to my medical records and personal details held by the practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record that are excluded:

_____
_____
_____

I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

I do/do not consent to my carer receiving copies of all correspondence relating to my treatment (*delete if not applicable*). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Signed _____ (Patient) Date _____

Accepted by _____ (Doctor) Date _____

Office Use Only:

Copy Frequency	
Specific Copy Exclusions	
Specific Copy Inclusions	