EMIS:……

SUMMERVALE SURGERY

PERMISSION FOR PATIENT MEDICAL INFORMATION TO BE GIVEN TO A THIRD PARTY

Name of Patient:…….. D.O.B…….

I give permission for: ……..

Their Contact Numbers Are:……..

Relationship to Patient: ……**Is My Next of Kin**: **Yes/ No** (please circle)

They may contact the surgery on my behalf to obtain any medical information that may be required on my behalf (including test results). I also give consent for Summervale Surgery to inform the third party listed above where they are calling from if the third party needs to be contacted.

I understand that future information will be available to the named person unless I inform the surgery in writing to cancel this instruction.

SIGNED:…… **Date:**……