xxxxxxxx HEALTH CENTRE

Information Sharing Agreement between

Patient and CARER or RELATIVE

This form is designed so that a carer or relative can contact the Health Centre and be given information regarding a patient from whom they have received consent to do so. This form can be used for unpaid carers, social work carers and relatives.

|  |  |
| --- | --- |
| Patient Name: |  |
| Patient Date of Birth: |  |
| Patient Address: |  |

|  |  |  |
| --- | --- | --- |
| Carer(s) Name(s): | | Relationship to Patient |
|  | |  |
| Carer(s) Telephone number: | Home Number: | |
| Mobile Number: | |
| Carer(s) Email: | | |

Consent Declaration (to be completed by patient)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I give permission for my Carer(s)/Relative(s) listed above to have access to information in my medical record. Please detail below if the access is to be limited in any way (e.g. only for test results, or for making & cancelling appointments, or for a specified time period only).  I give permission for: (Please tick appropriate box)   |  |  | | --- | --- | | * Access to my test results |  | | * Making and Cancelling appointments |  | | * Access to information about specific condition only (please detail below) |  | | * Access to information in all of my medical records held at Lerwick Health Centre |  |   Where the permission is restricted to part of the record only and/or specific condition(s), please specify below the precise limits of this permission, and any areas of the record which 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.

|  |  |  |
| --- | --- | --- |
|  | | Date: |
| Patient Signature: |  |  |

Admin staff:

|  |  |
| --- | --- |
| Alert put on patient notes & passed to scanning (please initial) |  |
| Date: |  |