APPLICATION FOR THIRD-PARTY ACCESS TO HEALTHCARE INFORMATION

To maintain confidence in our patients, at Higham Ferrers Surgery we will not divulge any medical information about you unless it is legally appropriate, or we have your consent to do so.

Who should complete this form?

Anyone who is competent to do so.

It is difficult to state at what age any child will become competent to make autonomous decisions regarding their healthcare as between the ages of 11 and 16 this varies from person to person. As most children are content that their parents have access to their healthcare information, this form will ordinarily be used for adults. However it may equally be used for a child whom it is considered has capacity and can understand their actions.

Agreement

Should you wish to consent for a nominated person to be able to discuss any medical information about you with staff at this practice, please indicate this in the form overleaf.

Although by completing this form, the following should be noted:

- The person granting access to a third-party must fully complete and sign the form
- Any incorrectly completed forms will not be processed and will be returned to person making the application
- This form does not permit any third-party individual to make healthcare decisions on behalf of the named patient
- This practice may contact you via email or telephone should there be any concern

Disclaimer:

It is also your responsibility to keep us informed as to who can access and discuss specific areas of your medical record as detailed on the form. Should your circumstances change, it is your responsibility to advise this practice.

Higham Ferrers Surgery relinquishes all responsibility should the above information become incorrect if not updated.

I, …………………………… (insert name) hereby give permission for Higham Ferrers Surgery to discuss my medical records with the following:

Higham Ferrers Surgery

Patient requesting permission to allow third party access		
Full name		
Date of birth		
Address		
Signature		
Date		
Telephone/Email		

Named person receiving access	
Full name	
Contact No:	
Address	
Relationship	

Agreement as to what can be divulged

I give permission for the following to be permitted or discussed with the above named person should they request (tick all that apply):

Appointments	Medication	Consultations	Test results	Referrals
☐	☐	☐	☐	☐

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

Signed (Patient)		**Date**	
Accepted by (GP)		**Date**	

Staff use only	Patient warning updated and Family/Relationship links updated	Document passed to be scanned

Updated 21.09.2023