THIRD PARTY ACCESS TO A PATIENT'S PERSONAL DETAILS AND/OR COPIES OF CORRESPONDENCE AGREEMENT

Patient's Name:

Patient's DOB:

Patient's Address:

I hereby grant permission for:

Name:

Relationship to Patient:

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 limits of this permission, and any areas of the records which are excluded:

I understand that this permission will remain in force until cancelled by me in writing.

Patient's Signature:

Dated: