Greystones
Medical Centre

# CONSENT FORM

## for another individual to gain access and/or to discuss my medical record

| | |
|---|---|
| **Patient name** | |
| **Date of birth** | |
| **Address** | |

I am a patient at Greystones Medical Centre and give authorisation to the named individual below to:

◯ have full access to my medical records
◯ order my repeat prescription
◯ make appointments

(tick all that are applicable)

I understand the contact details of the individual will be recorded on my medical record.

**Signature of patient:**

**Date:**

### Contact details of the individual who I authorise

| | |
|---|---|
| **Full name (print)** | |
| **Telephone number** | |
| **Relationship to patient** | |

☐ (Please tick)

I understand if any of the consent contact details change or I wish for them to be removed from my medical record I will contact the surgery immediately. (A 'remove/change to consent form' is available from our Reception)

***October 2021***