Bruntsfield
Medical
Practice

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Providing high quality healthcare in partnership with our patients

CONSENT FORM TO SHARE / DISCUSS PATIENT INFORMATION WITH THIRD PARTY

CONSENT GIVEN:

I, (write name and dob) _____, give consent for the person or persons named below to discuss my health and social care with staff at Bruntsfield Medical Practice.

I understand that this may include information on my appointments, medical history, diagnoses and procedures, test results and information received from hospital and clinics.

I am aware that I can revoke this consent at any time by contacting the Practice.

Signed: ..... Date: .....

CONSENT REVOKED:

I, (write name and dob) _____, wish to remove consent for the person or persons named below to discuss my health and social care with staff at Bruntsfield Medical Practice.

I am aware that I can reinstate this consent at any time by contacting the Practice.

Signed: ..... Date: .....

Name	Relationship to named patient