*Dounby Surgery* Dounby Orkney KW17 2HH

**CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION**

Name: ­­­­: TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION Date of Birth:

Address:

I hereby consent to the disclosure of my private medical information to:

Name: ­­­­: TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION Date of Birth:

Relationship: Tel No:

Address:

Please tick the statement/s applicable:

* Full and open ended disclosure of any matter related to my medical record
* Limited disclosure of the following aspects of my medical record:
	+ Test Results
	+ Prescription queries
	+ Appointment queries
	+ Referral queries
	+ Any other matter related to my medical record, please state:

* + From To

**I am aware that this consent may be revoked by me at any**

**time, in writing to the Practice Manager**

Signature: Date:

Witnessed by (not the individual for whom consent is being granted):

Signature: Date:

Address: