**PATIENT’S CONSENT TO SHARE NHS DATA WITH**

**A NAMED THIRD PARTY**

*NOTE WE NEED ONE FORM PER PATIENT*

WE NEED FORMAL CONSENT IF YOU WANT INFORMATION SHARED WITH A THIRD PARTY

Reception and appointments staff often have husbands, wives, parents, carers etc asking for test results or other information which they cannot disclose without formal consent from the patient.

It often can appear that the staff member is being bureaucratic and unhelpful when they are in actual fact simply complying with NHS and doctor’s recommendations to safeguard the confidentiality of patient information. It is vital that patients have confidence that their health records are safely kept in the strictest confidence and that if information is shared they have given their prior consent to this. If you want to give consent to a named 3rd party please complete this form.

|  |  |
| --- | --- |
| Enter your full name |  |
| Enter your date of birth |  |
| Enter your address |  |
| Mobile |  |
| Email |  |

Give formal consent for Channel View Medical Group to share the following information to the named person on this form:

By ticking the box(es) you are consenting to that information being shared, you can choose just one or as many as you wish.

Please Tick

|  |  |
| --- | --- |
| Online Access |  |
| Repeat Prescriptions |  |
| Test Results |  |
| Medical information from my confidential NHS health records (consultations, vaccine information, information from secondary care) |  |

Enter below the name of the third party that you wish to share your medical information with.

|  |  |
| --- | --- |
| Name |  |
| Date of Birth |  |
| Address |  |
| Telephone Number |  |
| Relationship to the patient |  |

Is the named person aware that you have provided us with their information? Please tick.

|  |  |
| --- | --- |
| Yes |  |
| No |  |

I consent to the practice sharing this information until:

|  |  |
| --- | --- |
| Specific Date: |  |
| Indefinitely: |  |

I understand that it is my responsibility to update the practice if I no longer want the named person on this form to have access to my medical information. I understand that I can withdraw this consent at any time by giving 48hrs notice in writing.

|  |  |
| --- | --- |
| Signed: |  |
| Date: |  |

**For practice use only:**

|  |  |
| --- | --- |
|  | *Add read code XaNwR* |
|  | *Add reminder to S1 and brief description of third party including contact details* |
|  | *Add a scheduled task to S1 if a set date has been specified for removal of consent* |
|  | *If the patient is under the age of 16 years please set a scheduled task for their 16th birthday to contact them regarding continuation of the third party access* |