**The Lambert Medical Centre**

2 Chapel Street, Thirsk, YO7 1LU

Tel No. 01845 523157

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| **PATIENT DETAILS** | **CARER/ RELATIVE DETAILS** |
| **Name** | **Name** |
| **Address** | **Address** |
| **Post Code** | **Post Code** |
| **Telephone** | **Telephone** |
| **E-Mail** | **E-Mail** |
| **Mobile** | **Mobile** |
| **Date of Birth** | **Relationship to patient** |

**I give permission for my relative/carer to have access to my medical records and personal details held by the Practice and for staff to discuss this with my relative/carer.**

**This permission relates to all of my records including but not limited to medication, appointments, referrals and test results.**

**I understand that this consent will remain in force indefinitely. However, my doctor may override this authority to remove access to specific items if they feel it is in my best interest.**

**Signed.............................................................................. (Patient)**

**Date..................................................................................**

**I will treat any information provided confidentially , I will not disclose information to a third party without agreement and will only use the information in the best interest of the person I care for.**

**Signed................................................................................ (Carer/relative)**

**Date...................................................................................**