**Application for Third Party Access to Healthcare Information**

To maintain confidence in our patients, at White House Farm Medical Centre we will not divulge any medical information about you unless it is legally appropriate, or we have your consent to do so.

**Agreement**

Should you wish to consent for a nominated person to be able to discuss any medical information about you with staff at this practice, please indicate this on the form below.

By completing this form, the following should be noted:

* The person granting access to a third party must fully complete and sign the form
* Any incorrectly completed forms will not be processed and will be returned to the person making the application
* This form does not permit any third party individual to make healthcare decisions on behalf of the named patient
* This practice may contact you should there be any concern

**Disclaimer:** It is your responsibility to keep us informed as to who can access and discuss specific areas of your medical record as detailed on this form. Should your circumstances change, it is your responsibility to advise the practice. White House Farm Medical Centre relinquish all responsibility should the information provided on this form become incorrect if not updated.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give permission for White House Farm Medical Centre to discuss my medical records with the following:

|  |  |
| --- | --- |
| **Patient requesting permission to allow third party access** | |
| Full name |  |
| Date of birth |  |
| Address |  |
| Signature |  |
| Date |  |
| Telephone/Email |  |
| **Named person receiving access** | |
| Full name |  |
| Address |  |
| Relationship |  |

**Agreement as to what can be divulged**

I give permission for the following to be permitted or discuss with the above named person should they request (tick all that apply)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Make Appointments | Appointment Information | Discuss Medication | Request Medication | Receive/discuss test results | Discuss Consultations | Discuss referrals |
|  |  |  |  |  |  |  |

**PLEASE NOTE:**

* We are required to check your ID when processing your Third Party Access request. We are also required to check the ID of the third party to whom you are giving access.
* We retain the right to reject any application to give consent to a third-party, where we consider it given wrongfully, under duress, or inappropriate in any other way.
* You are able to freely withdraw your consent to share your medical information with your third party at any time. Please contact us to do this.
* This advice and the third-party consent form is NOT designed to be used for giving consent for matters such as reports, forms, insurance application data releases, etc. This advice relates specifically to giving consent for a third-party to act on your behalf.

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**For Practice use only**

|  |  |
| --- | --- |
| Date form received |  |
| Form of ID checked for both parties |  |
| Staff initials (received by and ID verification) |  |
| Consent granted or denied, (specify date if granted) |  |
| Form put to be added to patient record (date) |  |