Waddesdon Surgery
PATIENT AUTHORISATION FORM

FORM ONLY TO BE COMPLETED BY PATIENT OVER THE AGE OF CONSENT (16 YEARS OR OLDER), SHOULD THEY WISH TO SHARE MEDICAL RECORDS WITH A NOMINATED AUTHORISED PERSON.

PATIENT DETAILS	
Surname	
Forename(s)	
Date of Birth	
Telephone Number	
NHS Number	
Current Address Full Postcode	

I,_____herby give authorisation for the following information to be shared with_____.

INFORMATION TO BE SHARED:

☐ ALL RECORDS **or**

☐ Future & Past Appointments ☐ Consultation records ☐ Results records

☐ Medication Records ☐ Other: _____

This information will be shared until such time as the named patient notifies Waddesdon Surgery to the contrary.

Signed:_____Date: _____

DETAILS OF AUTHORISED PERSON			
Full Name			
Date of Birth		NHS Number	
Contact Number(s)			
Relationship with individual (if applicable)			
Authorised Person holds Power of Attorney for Patient	**Please tick relevant box, copy of POA will be required.** ☐ Lasting Power of Attorney for Health & Welfare, English & Welsh Law ☐ Welfare Power of Attorney, Scottish Law ☐ Enduring Power of Attorney, Northern Irish Law ☐ Power of Attorney, other		

IS THE AUTHORISED PERSON YOUR NEXT OF KIN	☐ **Yes** ☐ **No**
IF NOT PLEASE PROVIDE NEXT OF KIN NAME AND CONTACT NUMBER	