WEST HIGHLAND MEDICAL GROUP

The Pines, Acharacle, PH36 4JU

Patient Consent Form – Over 18 year olds

For another person/s to be allowed access to their medical records/discuss matters relating to medical information by telephone or in person

Patient Details	
Surname	
First Name	
Date of Birth	
Address	
Telephone Number	

Details of Person/People to whom you give consent to access above patients information	
Person Number 1	
Full Name	
Address	
Relationship to patient	
Person Number 2	
Full Name	
Address	
Relationship to patient	

Please detail below if the above access is to be limited in any way (e.g. only for test results or making/cancelling appointments or for a specific time period only) If no information is given below full access will be allowed

I confirm that I give permission for the practice to communicate with the person/people identified above in relation to my medical records. This consent will remain in place until revoked in writing.	
Full Name	
Signature	
Date	