MEDDYGFA
MOSTYN HOUSE
MEDICAL PRACTICE

THIRD PARTY ACCESS – SHARING OF INFORMATION CONSENT FORM

In order to protect confidentiality, we usually insist that patients contact us themselves to discuss medical matters or to receive test results and other information. However, we do understand at times that this may not be possible. The completion of this form will authorise Mostyn House Medical Practice to discuss information regarding your health needs with a third party (i.e. family member/carer) named in Section 2 of this form.

SECTION 1: Patient's details

Full name	
Date of birth	
Address	
Contact Telephone Number	

SECTION 2: Details of the named third party

Full name	
Address	
Contact Telephone Number	
Relationship to the Patient	

STATEMENT of DISCLOSURE
☐ I give permission for Mostyn House Medical Practice to share the following information with the person (third party) named in Section 2 (Please choose from Option 1 or 2)
Option 1 - Limited disclosure of the following aspects of my medical record (Please tick the relevant boxes) Appointment information ☐ Prescriptions and medication ☐ Test Results ☐ Referrals / Hospital correspondence ☐ Medical Condition/s ☐ Other (please state) ☐ ……
Option 2 – Full and open ended disclosure of my medical record ☐
Please allow access: Indefinitely ☐ For a limited period only ☐ Please specify when this authority is valid until ……
PATIENT CONSENT I understand that this consent may be revoked by me at any time either verbally or in writing.

Patient signature	Date