Cardinal Medical Practice
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PATIENT CONSENT FORM FOR SHARING MEDICAL INFORMATION

Patient details:

Patient name: _____ Date of birth: _____

Address: _____

Home number: _____ Mobile number: _____

Work number: _____ Email address: _____

Relative/Friend's Details (who you are giving consent to):

Name: _____ Date of birth: _____

Address: _____

Home number: _____ Mobile number: _____

Work number: _____ Email address: _____

Relationship to Patient: _____

I hereby give consent for the above person details to be recorded on my medical record and for them to have access to my medical records and/or discuss my medical requirements.

Please tick the statement to confirm you consent.

Full and open-ended disclosure of any matter related to my medical record……☐

Patient signature: _____ **Date:** _____