The James Cochrane Practice

CONSENT TO DISCLOSE

1. Patient giving consent ***You give consent for the person below (Nominated Individual) to access your medical records.***	
Name	
Date of Birth	
Address	
Contact Number	

2. Nominated Individual ***This is the person that you are giving access to your medical records.***	
Name	
Date of Birth	
Relationship to above	
Address	
Contact Number	

3. Please tick the boxes for areas of access you grant to the above-named Nominated Individual.			
Ordering repeat prescriptions and queries		Viewing test results	
Viewing recent consultations		Viewing hospital letters	
Viewing immunisation and vaccination records		Referral Queries	
Any other matter related to my medical record (please state):			

4. Declaration by patient *(person giving consent)* **I am aware that this consent may be revoked by me at any time**	
Signature:	Date:

5. How long are you providing this consent for? *Please state specific time periods if applicable. Circle correct option*		
Open Ended	From:	To:

6. Witnessed by: ***Cannot be either of the above two named individuals***		
Name:	Signature:	Address:

PLEASE TURN OVER

Please complete your Next of Kin and Emergency Contact details so we can keep our records up to date.

7. Next of Kin details	
Name	
Landline Number	
Mobile Number	
Relationship to you	
Address	

8. Emergency Contact details	
Name	
Landline Number	
Mobile Number	
Relationship to you	
Address	

MENTAL CAPACITY *(PRACTICE USE ONLY)*

Does the patient have mental capacity? If yes, complete sections below. (Y/N)					
If no, send task to registered GP for further advice. Date task sent if no capacity					
If PN sent to clinician, was it authorised?	Y / N	Clinician initials		Date	

PATIENT CONFIRMATION *(PRACTICE USE ONLY)*

Make sure to say Nominated Individuals (NI) name to patient to make sure no confusion on who is getting access.

Name of staff member making phone call	
Date contact with patient made	
Time of contact	
Patient understands what information is being given to NI (Y/N)	
Patient consents to NI gaining access to specified areas overleaf (Y/N)	

SET UP *(PRACTICE USE ONLY)*

Only to be done once above has been filled in and patient has been spoken to.

Date coded:	
EMIS number of patient:	
EMIS number of Nominated Individual: (if applicable)	
Completed by: (staff name)	