LEIGH VIEW MEDICAL PRACTICE

Discuss my health with someone – consent form.

on behalf of

1. Patient's full name: ____
2. Patient's date of birth: ____
3. Patient's contact telephone number (during office hours):______________________________
4. I know that I need to show photo ID at reception when handing this form in *(to confirm I am the patient)* ☐.

I hereby consent to Leigh View Medical Practice speaking to the following person on my behalf:

5. Their name: ____
6. Their relationship to me: ____
7. Their telephone numbers:____

8. What **can be** discussed with this person?:
   ☐ **Everything** that they ask about me:
   This includes (but is not limited to):
   - To be given my **test results**
   - To be able to discuss questions about **my medication** or prescription requests
   - To be able to **ask details of my appointments** – e.g. times and dates and to be able to cancel appointments
   - To be able to talk about anything I've been referred onwards about
   - To be able to be informed what I have been diagnosed with, and my medical history.

Please note that information about medical history is never available over the phone to anyone. Requests for information contained in medical records should always be requested either in writing or through discusson with a clinical member of staff. If access to medical records is required, there is a different consent form available from the Medical Secretaries.

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9. Is this person also registered as a patient at Leigh View Medical Practice themself? Yes / No
   If yes: What is their date of birth: __________ (to link their contact details from their own record)
   If no: Please provide their full contact details:
   Address: ______________________________________ Phone: _________________________

10. Please tick the statement/s which are applicable:
    Are they your **next of kin**? Yes / No
    Are they your **emergency contact**? Yes / No
    Are they your **main carer**? Yes / No

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11. Signed and authorised by me, the patient:

I am aware that this consent may be revoked by me at any time in writing to the Practice Manager.

Patient signature: ___________________________________ **Date:**___________

☐ *I.D. of the patient shown at Reception by the patient themself _______ seen by Receptionist:_____ Date:*

ONLY TO BE COMPLETED IF THE PATIENT IS NOT CAPABLE TO CONSENT:

If the patient is aged 16 or over, they must sign this form themself and show photo ID to prove that this is their own request.
ONLY if the patient is incapable of giving consent can this form be signed on their behalf by someone else, providing that this representative has a legal "Lasting power of attorney (LPA) for health and care decisions" or other legal document confirming this authority.

Patient representative signature:____ Date:___________
☐ *I.D. of representative shown at Reception _________________________ seen by Receptionist:_____ Date:__________*
☐ *Legal authority e.g. "LPA for health and care decisions" ____________copy taken by Receptionist:____ Date: __________*
Full name, address and phone number of representative who has signed this on behalf of the patient:

Completed forms to be passed to data team