ABINGTON MEDICAL CENTRE
PATIENT CONSENT TO RELEASE INFORMATION

PATIENT DETAILS	
Patient Surname:	
Forename(s):	
Date of Birth:	
Address:	
Telephone Number:	

DETAILS OF THE PERSON I WISH TO HAVE ACCESS TO MY RECORDS	
Surname:	
Forename(s):	
Address:	
Date of Birth:	
Telephone Number:	
Relationship to Patient:	

I declare that I give the staff at Abington Medical Centre permission for the above named person to access my records.

They are entitled to access the following:

(Please delete as appropriate)

1. All of my record to include consultation details, results, appointments, hospital correspondence historic or current
2. Results only
3. Non-medical information only
4. Please specify

This consent will remain in place whilst I am registered at Abington Medical Centre until I inform the practice otherwise.

Patient Signature …… **Date:** ……..