Bridgnorth Medical Practice

Northgate Health Centre, Northgate, Bridgnorth, Shropshire, WV16 4EN
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Patient's Name: ____________________________ **Date of Birth:** _____________

Home Address: ____
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I give permission for (insert full name) _________________________________
Date of birth _________________________________
Address _________________________________
Telephone _________________________________

- have access to my medical records
- have access to personal details held by the Practice
- discuss my medical condition(s) and treatment
- discuss my medication
- order my repeat prescriptions online

(please delete any of the above list if you do not wish disclosure on those matters)

Please list any other information below which you DO NOT wish us to share with your nominated person

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Please indicate what levels of permission you wish the nominated person to have if you wish to apply restrictions. Where the permission is restricted to part of the medical records please specify below the precise limits of this permission, and any areas of the record which are excluded.

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I understand that this permission will remain in force until cancelled by myself in writing. A signed letter will be required to cancel this arrangement and e-mail or verbal changes to this request will not be accepted. A doctor may override this request, in the future if, in their opinion, it would be detrimental to my health to disclose information.

Nominated Person's Signature: _______________________________

Signed _______________________________ (Patient)

Date _________________________________