**Consent to Share Medical Records**

If you are filling out this form on behalf of another person or child under the age of 13, the practice will consider this request. Please ensure you fill out their details in section A and your details in section B.

Please note children over the age of 13 will need to complete this form themselves.

Please complete in BLOCK CAPITALS

**A. Please complete the following for the patient wishing to give consent/dissent.**

Forename(s): .............................................................

Surname: ...................................................................

Address: .....................................................................................................................................

…………........................................................................................................................................................................................................................................................................................

Postcode: ..............................................

Phone No: .............................................

Date of birth: .........................................

NHS number (if known): ...............................................................

**B. If you are not the person named in section A, please complete this section.**

Your name: ................................................................................................

Date of birth: .........................................

Relationship to patient: ............................................................................

**C. How the NHS will use your Data**

The following questions allow you to tell us how you would like Grove Medical Practice to **share your medical records with other NHS organisations**. If you leave any question unanswered, we will not make any changesto your record. Any previous sharing preferences you have given will remain in place. If you have notexpressed a preference previously, the default options will be applied.

**If you require more information about data sharing please ask at Reception or go to the NHS website.**

Do you consent to Grove Medical Practice **sharing your medical records** with other NHS organisations caring for you, for the purposes of **healthcare?** This is known as **sharing out.**

**YES** **NO** 

Do you consent to Grove Medical Practice **viewing the medical records** shared by other NHS organisations caring for you, for the purposes of **healthcare?** This is known as **sharing in.**

**YES** **NO** 

**Your signature**: ...................................... **Date**: ....................................................