MOWBRAY GROUP

Mowbray House and Hutton Rudby Surgeries

Consent to gain medical information from records

Patients details

Patients Name ……

Date of Birth ……..

Address……

……..

Telephone number ……

Dear Doctor,

Please accept this declaration as formal consent to disclose my medical records, both past and present, to:

Name ……

Relationship……....

Address……

……..

Telephone number ……

Does this person hold Lasting Power of Attorney for Health ……..Yes……..…..No…….

If YES please provide a copy for our practice records

Name ……

Relationship……....

Address……

……..

Telephone number ……

Does this person hold Lasting Power of Attorney for Health ……..Yes……..…..No…….

Signed…… Date……

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Fax: 01609 778029

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