Larkside Practice

Churchfield Medical Centre, 322 Crawley Green Road
Luton, Beds. LU2 9SB
Tel 01582 722143 - www.larksidepractice.co.uk

Discuss my health with someone else – consent form

Please complete this form if you wish to grant a representative the ability to communicate with us about you and your health.

Completing this form will enable the person(s) of choice to gain access to information about you and your medical problems, talk to us about your care, and give and receive information about you. A separate form will be required for each person being granted permission.

Giving consent to and for someone else to communicate with u about you and your medical problems is a very significant step and you should give it serious consideration. You need to consider what they might learn about you and your health, that you did not want them to know. Please note that no information from your medical history is ever available and access to information will only be given from the date of signature on this form.

By completing this form, you are advising that you have fully considered the ramifications of giving that consent. If you are unsure about giving consent, we advise that you do not give it and that you seek legal advice before proceeding.

About me (the patient)
Two forms of evidence must be shown by the patient, at the time of submitting this form, one being Photo ID and the other providing proof of address, (except in very exceptional circumstances), to confirm that they are the patient submitting this form. This is very important to demonstrate that this request is definitely from the patient.

Patient's full name	
Patient's date of birth	
Patient's NHS number (if known)	
Patient's contact telephone number	

About them (the person who will now have access):

The name of the person I am giving access to	
Their relationship to me: e.g. Neighbour/relative/friend	
Is this person also registered as a patient at Larkside Practice	Yes [ ] No [ ]
Their telephone number	
Would you also like them to be recorded on file as your Next of Kin and/or Emergency Contact	Yes [ ] No [ ]

If the patient is aged 13 or over, they must sign this form themselves and show photo ID to prove that this is their own request.

What information can be shared with this person: (please tick)

[ ] To be given test results and immunisations
[ ] 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, to be able to cancel appointments and make appointments where necessary
[ ] To be able to discuss any referrals that have been made on my behalf
[ ] To be able to see my medical record, be informed what I have been diagnosed with, and see my whole medical history]
[ ] All of the above
[ ] Other (please specify) ……..

Access to records is available online through the NHS app. https://www.nhs.uk/nhs-app/

N.B. if access to a printed copy of medical records is required, there is a different consent form available from Reception.

This new system doesn't affect existing patients with existing people authorised on their records, nothing will be removed or changed, unless at the request of the patient, but this consent form applies to all new requests made on 1st April 2024 and onwards.

YOU CAN CHANGE YOUR MIND. Consent may be revoked by the patient at any time, by putting this in writing to:"Larkside Practice". A copy of this form will be retained in the medical record.

Signed and authorised by me, the patient:

Patient's Signature: …….. Date: ……

This extra section only applies if a patient is not capable to consent:

If a patient is incapable of giving consent, this form can be signed (above) on their behalf by some 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 and leave a copy of such legal document with the form (please never leave the original copies).

Full name, address and telephone number of representative who has signed this on behalf of the patient.

Patient representative full name	
Patient representative date of birth	
Patient representative address	
Patient representative telephone number	

Office Use: Reception staff to complete this section Copy of this form coded XaNwR [ ]
Photo ID – Checked [ ] LPA copy attached if required – [ ]
Other ID – Checked [ ] Copy of this form scanned – [ ]

DISCLAIMER: Should your circumstances change, **it is your responsibility to keep us informed.** Please contact the surgery if we need to amend the details for your next of kin or emergency contact. It is also your responsibility to keep us updated regarding who can access and discuss specific areas of your medical record as outlined above. The Practice bears no responsibility for any subsequent consequences should these details not be kept up to date.