Dr Tim Hooper
Dr Peter Hemingway
Dr Alison Westwell
Dr Kamila Winterbottom

Castlehead Medical Centre
Ambleside Road
Keswick
CA12 4DB

Tel 017687 72025

CONSENT TO DISCUSS MY MEDICAL INFORMATION
Including 13-16 year olds

(Patient name).....date of birth……..

of address……..

Give my consent to Castlehead Medical Centre to provide my personal medical information to the nominated person(s) named below which must be adequate, relevant not excessive and accurate:

1. Consent given to (name).....

Relationship to me.....

Tel contact Home……Mobile……

Signature (of nominated person)……Date……
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

2. Consent given to (name).....

Relationship to me.....

Tel contact Home……Mobile……

Signature (of nominated person)……Date……
By signing this you are agreeing that you give consent for Castlehead medical centre to hold your personal data until this consent is withdrawn by either party.

If you would like to add any exclusion to this, please list these below, otherwise we will accept this as consent given to discuss or disclose anything in your medical records.

Items to be excluded: ……

……

I understand that this consent form will remain in place until I give written advice to Castlehead Medical Centre to have this withdrawn and I accept that it is my responsibility.

Signed……Date……

Office use only	Date	Initial
Alert added to patient record, including contact tel numbers of 3rd party		
Code added 9NdG		