**THE CENTRE SURGERY**

**CONSENT/PERMISSION TO DISCLOSE DATA TO NAMED**

**3RD PARTY PERSON**

Name of patient ………………………………………………………………………Date of Birth …………………..

Address ……………………………………………………………………………………………………………………………..

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

Telephone

Number …………………………………………………………………………………………………………………………….

I hereby consent and give permission for **THE CENTRE SURGERY** to disclose information regarding my medical conditions to the following named 3rd party person:

Name …………………………………………………………………………………………………………………………………

Address ………………………………………………………………………………………………………………………………

Telephone

Number……………………………………………………………………………………………………………………………….

Relationship to

Patient………………………………………………………………………………………………………………………………….

On signing this form please note that information given out may be regarding medical problems as well as current or future conditions. If there are any medical condition or any part of your medical records that you do not wish the above person to be told about you must notify us.

I understand that this agreement will continue until I notify you otherwise.

Signature of patient………………………………………………………..Date:………………………………………..