

**THE MERRYWOOD PRACTICE**

Patient consent to release information to another person

Patient Name :

Patient Address:

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I authorise The Merrywood Practice to give information from my practice medical records to

List names and relationship below

**1. Name ..... Relationship .....**

Address

Postcode

Telephone number(s)

Is this person (tick all boxes that apply)

- Your next of kin
- Someone we can contact in an emergency
- Allowed to discuss your medical records

**2. Name ..... Relationship .....**

Address

Postcode

Telephone number(s)

Is this person (tick all boxes that apply)

- Your next of kin
- Someone we can contact in an emergency
- Allowed to discuss your medical records

I agree that if I wish this arrangement to be stopped I will notify the practice in writing

Signature of Patient .....

Date .....