**RIVERSIDE SURGERY**

**INFORMATION SHARING AGREEMENT BETWEEN PATIENT AND CARER**

**By completing this form, the patient gives consent for their Carer to access their Medical Records and information relating to their care.**

|  |  |
| --- | --- |
| Patient’s Name |  |
| Patient’s D.O.B. |  |
| Patient’s Address |  |

* I give permission for my Carer [insert carer name]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to have access to my medical records and personal details held by the Practice.
* This permission relates to all / part of my record / specific condition only (delete as appropriate).
* Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded.

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I understand that the doctor may override this authority at any time, and that this permission will remain in force until cancelled by me in writing.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Doctor)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Proxy Online Access is wanted, please complete the separate form – Patient Registration Form for Proxy Access online services**