BIRCHWOOD MEDICAL PRACTICE

ACCESS TO PATIENT RECORDS CONSENT FORM

1. PATIENT DETAILS	
Surname	
First Name(s)	
Date of Birth	
Address	
Telephone Numbers	

2. DETAILS OF PERSON YOUR RECORDS CAN BE SHARED WITH	
Full Name	
Address	

3. Please detail below if the access is to be limited in any way. E.g. only for test results, or only for appointment booking, only for a limited time period

I, the undersigned confirm that I give permission for Birchwood Medical Practice to communicate with the person identified on this form relating to my full medical records unless otherwise stated in section 3 above.			
Signature		Date	

Consent for children under the age of 16 years (Gillick Competence)

Everyone age 16 years and over is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), they will be competent to give consent for themselves.

Therefore, young people aged 16 and 17 years, and legally competent younger children may, sign this Consent Form themselves. They may also wish for a parent/care to countersign as well.

Where the child is not able to give consent for themselves someone with parental responsibility should do so on their behalf by signing this form below in addition to the patient signature overleaf.

I am the parent / legal guardian of the person named overleaf and am providing countersignature to this consent form and the provision of medical information to a 3rd Party			
Signature		Date	
Address (if not the same as the patient named overleaf)			