EAST CALDER & RATHO MEDICAL PRACTICE

CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____

I hereby consent to the disclosure of my private medical information to:

Name: _____

Address: _____

Please tick the statement/s applicable and indicate the period of time that you require your private medical information to be disclosed:

Disclosure of the following aspects of my medical record:

- *Test Results* ☐
- *Prescription queries* ☐
- *Appointment queries* ☐
- *Referral queries* ☐
- *All Aspects of Medical Record* ☐
- *Any other specific relevant matter related to my medical record, please state:*_____

  _____

Date from: ..... *Date to: .....*

I am aware that this consent may be revoked by me at any time.

Signature: _____ Date: _____

If you need assistance in completing this form please ask a member of staff.

Practice use only

☐ ID verified

☐ Alert added

☐ Scanned

Initials.....