Green Street Green Medical Centre
21/21A High Street
Green Street Green
Orpington
Kent, BR6 6BG
Tel. 01689 850012
www.gsgmc.co.uk

Carer's Identification Form

YOUR DETAILS

Name			
Address		Date of Birth	
		Home Phone	
Post Code		Mobile Phone	
Any relevant information			

DETAILS OF THE PERSON YOU LOOK AFTER

Name			
Address		Date of Birth	
		Home Phone (If different)	
Post Code		Mobile Phone (If different)	
GP details (If different)			

☐ Please pass my details to the Carer's Service

☐ Please refer me to Adult Care Services for a Carer's Needs Assessment

Signed:_____

Please complete this form and hand it to our Receptionist

Thank you for completing this form

Only Complete this form if you would like your Carer to have access to your personal details and medical records in order to assist you with your care.

Patient Consent to allow a Carer to have access to their Personal Details and / or copies of correspondence.

Patient's Name	
Patient's Address & Post Code	

To: Green Street Green Medical Centre

I give permission for my Carer, _____ (Insert Carer's Name), to have access to my personal details and medical records held by the Green Street Green Medical Centre.

Delete those, which are NOT applicable:

This permission relates to all my records.

The permission relates to part of my records.	
Please specify the parts of the record to which access is allowed and any areas, which are specifically excluded.	

This permission relates to a specific condition.	
Please specify the condition.	

The permission relates to my Carer receiving copies of all correspondence relating to my treatment.
I confirm that my GP has explained this to me and has sole discretion to withhold any or all copies.

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

I consent to my Carer receiving copies of all correspondence relating to my treatment (delete if not applicable). I confirm that this has been explained to me by my GP and that the GP has sole discretion to withhold all or any copies.

Patient's Signature: _____Date: _____

Accepted by Doctor: _____Date: _____

Confirmed by Practice Manager _____ Date: _____