Green Street Green Medical Centre

THIRD PARTY CONSENT FORM

(If you wish to register a third party for representation, please submit this form)

*** Please be aware that you may change your mind at any time and may cancel this consent by contacting the Surgery***

Your First Name(s)	Your Last Name	Your Date of Birth

Your Phone Number	Your Email

Third Party Details:

I hereby authorise:

Full Name of Third Party	Relationship to you	Phone Number of Third Party

Home Address (Including postcode

To discuss my care and medical records and act on my behalf in relation to the healthcare I receive from Green Street Green medical Centre.

I also fully consent to Green Street Green medical Centre disclosing to the person named above any information, including personal data held by Green Street Green Medical Centre for the purpose of providing my medical care.

Please update my records accordingly. I will notify Green Street Green medical Centre should I change my mind.

Signature	Date