

**Port Glasgow Medical Centre
Patient Consent Form**

All our patients are entitled to keep their health records confidential. This includes children under the age of 16 if, in the health professional's opinion, they are capable of understanding the nature and consequence of their treatment.

To authorise another person to receive medical information on your behalf:

Patient details (The person whose records another individual(s) is to be given access to)	
Full name	
Date of Birth	
Address	
Telephone number	

Details of person to be given access to this Patient's information	
Full Name	
Relationship to patient	
Address	
Telephone Number	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.	
Signature	
Date	