Linden Medical Group
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Agreement by a Patient to allow a Carer to have access to their Personal Details and / or Medical Records

Patient's Name	
Patient's Address & Post Code	

To: Linden Medical Group

I give permission for my Carer, (Carer's name :…….....) to have access to my personal details and medical records held by the Practice. (Details below)

Please tick which option is applicable below:

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.	

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.

By signing below I consent to the above information being recorded on my medical record.

Print Name: _____ Signed Patient: _____

Date: _____