CONSENT FOR RELEASE OF MEDICAL RECORDS

I (Name) _____ Date of Birth _____

Address _____

_____

_____

_____ Post Code _____

Confirm my consent to medical records about me held by the Healthcare Group being released, by the Healthcare Group, to:

Name _____

Relationship to Patient _____

Address (if different to above) _____

_____

_____

_____ Post Code _____

Contact Telephone Number _____

and I authorise the Healthcare Group to release information to the above party/parties.

I understand that at any time I can withdraw this consent.

The above consent will apply until such time as I withdraw it. The above consent applies only to information relating to the following condition/treatment/matter:

_____

_____

_____

Signature		**Date**	