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| Dorridge Surgery**AGREEMENT FOR A CARER TO HAVE ACCESS TO A** **PATIENT’S PERSONAL DETAILS** **and/or COPIES OF CORRESPONDENCE** | logo |

|  |  |
| --- | --- |
| Patient’s Name |  |
| Patient’s Address |  |

To: **Dorridge Surgery**

I give permission for my Carer ………………………………………… to have access to my medical records and personal details held by the Practice.

This permission relates to all / part of my record / specific condition only (*delete as appropriate*).

Where the permission is restricted to part of the record only, please specify below the precise limits of this permission, and any areas of the record which are excluded.

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

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.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Doctor)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only:

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| Copy Frequency  |  |
| Specific Copy Exclusions |  |
| Specific Copy Inclusions |  |