Bow Medical Practice
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AGREEMENT FOR A NOMINATED PERSON TO HAVE ACCESS TO A PATIENT'S PERSONAL DETAILS and/or COPIES OF CORRESPONDENCE

Patient's Name	
Patient's Address	

I give permission for my NOMINATED PERSON

Full name: ……………………………………………………………….
Address: ……………………………………………………………….

to have access to my medical records and personal details held by the Practice.

This permission relates to all of my record / 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 NOMINATED PERSON 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 ____________

Signed _______________________________ (Nominated Person) Date ____________

Accepted by ____________________________ (Doctor) Date ____________

Office Use Only:

Copy Frequency	
Specific Copy Exclusions	
Specific Copy Inclusions	

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