THIRD PARTY ACCESS AND COLLECTIONS

With the introduction of data protection laws (GDPR) we are required to have your permission if you wish for a third party to collect any items (e.g. Prescriptions, Letters, Test Request Forms) on your behalf or for a third party to discuss your medical care.

Please complete the relevant section below detailing any third parties you wish to be able to act on your behalf and return this signed form to us as soon as possible.

You can stop a third party from acting on your behalf at any time by letting the surgery know.

PATIENT DETAILS

Name ……………………………………………….………………Date of birth………………………………………………

Address …………………………………………………….……………….………………………………………………………...

Phone Number…………………………………………….…………………………………………..……………………………

Signed …………………………………………………………..……………Date…………………………………………………

THIRD PARTY DETAILS

Name ………………………………………………………………Date of birth………………………………………………

Relationship (who third party is to you) ……………………………………………….………….….………………

Phone Number ………………………………………………………………………………………………….….…….……….

Actions you consent to:

 All Collect prescriptions/paperwork on your behalf

 Access information regarding test Speak on your behalf

 results and medication only

If you give permission for more than one third party to act on your behalf please continue overleaf.

THIRD PARTY DETAILS

Name ………………………………………………………………Date of birth………………………………………………

Relationship (who third party is to you) ……………………………………………….………….….………………

Phone Number ………………………………………………………………………………………………….….…….……….

Actions you consent to:

 All Collect prescriptions/paperwork on your behalf

 Access information regarding test Speak on your behalf

 results and medication only

THIRD PARTY DETAILS

Name ………………………………………………………………Date of birth………………………………………………

Relationship (who third party is to you) ……………………………………………….………….….………………

Phone Number ………………………………………………………………………………………………….….…….……….

Actions you consent to:

 All Collect prescriptions/paperwork on your behalf

 Access information regarding test Speak on your behalf

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Name ………………………………………………………………Date of birth………………………………………………

Relationship (who third party is to you) ……………………………………………….………….….………………

Phone Number ………………………………………………………………………………………………….….…….……….

Actions you consent to:

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 Access information regarding test Speak on your behalf

 results and medication only