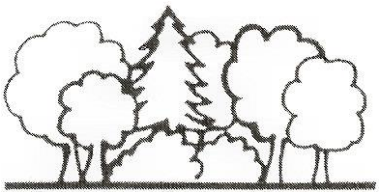
DR. CAROLYN PRIOR
DR. PANDU BALAJI
DR. EMANUEL HACIATURIAN
DR. HAROON MUFTI

WOODLANDS PRIMARY CARE



146 HALFWAY STREET
SIDCUP
KENT
DA15 8DF

TEL. NO. 020 8300 1680

Permission Form; for a person to access and discuss my medical records

Everyone 16 years or over needs to contact the surgery for their own results and medical information. Due to patient confidentiality, we cannot give information about any patients 16 years or over to anyone else.
If you would like to give permission for another person to access your medical records, or collect documents on your behalf, please fill in this form and return it to surgery. We will then add to your notes that you have given written permission for this access.
This permission can also be removed at any time by request.
Please read the form carefully and fill in all sections. We cannot accept the form if any information is missing.
If you would like to allow access to more than one person, please fill in a separate form for each person.
Please contact the surgery on 0208 300 1680 if you have any questions or queries.

First name: _____ Surname: _____
Date of birth: _____ Email (if applicable): _____
Address:_____
Home number (if applicable): _____
Mobile number (if applicable): _____

I give permission for Woodlands Primary Care to give;
Name: _____ Date of birth: _____
Contact number: _____
Relationship to me: _____ access to my medical records.

Please tick all of those which you CONSENT to the above named person doing on your behalf;

- Collecting my letters and/or forms ☐
- Collecting my prescriptions ☐
- Discussing my medical records in detail ☐
- Calling to book, amend or cancel my appointments ☐
- Calling for my results ☐

I am signing to the effect that I wish to allow access to my medical record to another person, and understand and agree with each statement below:

1. I have read and understood the information on this form.
2. If I choose to share my information with anyone else, this is at my own risk.
3. I will contact the practice immediately if I suspect that my medical record is being accessed by someone without my agreement.
4. I reserve the right to reverse any decision I make in granting access at any time.
5. I give consent for my full medical record to be shared with this named person.

Signed: _____ Date: _____

Please return this form to surgery reception. Thank you.

Form Amended: September 2023