ST PETER'S MEDICAL PRACTICE

Consent form

I ……(FORENAME SURNAME) I consent to the sharing of my patient record

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to Drs Surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share out - please circle your choice

I would / would not like the information recorded at St Peter's Medical Practice to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data

Share in – please circle your choice

I would / would not like the information recorded at other care teams who are involved in my care to be seen by members of the team at St Peter's Medical Practice where I have granted those care teams the right to add to my shared data

SMS TEXT MESSAGING – please circle your choice

I would / would not like to receive txt messages from St Peter's Medical Practice (reminding/inviting of appointments

I understand that I can change my decision at any time

Signed

Patient…….. Date ……

OR

Patient representative…… Relationship to patient ……