**ABBEY MEADS MEDICAL GROUP**

**CHOOSING WHICH ORGANISATIONS CAN VIEW YOUR MEDICAL RECORDS**

Having read the information sheet, please choose ONE of the following options below andsend/email/hand it to reception or to any member of the practice staff

1. **SHARING INFORMATION FROM YOUR GP RECORDS**

 Do you consent to the sharing of data recorded here with any other

 healthcare organisations also caring for you?

* ***YES*** *– share data with other organisations with no*

*additional security\* (tick box)*

***OR***

* ***YES*** *– share data with other organisations, but I wish*

*to provide additional security, and I confirm that I have*

*provided the practice with a mobile telephone number (tick box)*

*and an email address, and that I will ensure that the*

*practice is notified if either of these details change\**

***OR***

* ***NO*** *– do not share any data recorded here with any*

*other organisation providing me with healthcare (tick box)*

***\* Please see the attached leaflet for further information***

***AND***

1. **SUMMARY CARE RECORD (“the Spine”)**

Having read the information sheet, please choose ONE of the following options below andsend/email/hand it to reception or to any member of the practice staff.

 ***A.******Yes I would like a Summary Care Record –*** *express consent for medication, allergies and adverse reactions only.*

 *(tick box)*

***OR***

***B.******Yes I would like a Summary Care Record –*** *express consent for medication, allergies and adverse reactions* ***and*** *additional information*

 *(tick box)*

***OR***

 ***C. No – I would not like a Summary Care Record***

 *(tick box)*

 **Personal Details on page 2 MUST be completed**

**PERSONAL DETAILS – FORMS WHERE THIS SECTION IS BLANK WILL NOT BE ACTIONED**

1. **Please complete in BLOCK CAPITALS**

Title: \_\_\_\_\_\_\_\_\_ Surname / Family name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forename(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_ / \_\_\_ / \_\_\_ NHS No. (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_

**B. If you are filling out this form on behalf of another person or child** please ensure you fill out their details in section **A.** and your details in section **B.**

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

*\*In signing, you are confirming that the patient is (a) a minor; (b) lacks capacity to make the decision, or (c) that you have their consent to complete the form on their behalf.*