Dr A Saunders
Dr R Ganesalingam
Dr R Hambleton
Dr R Foster
Dr S Simkin
Dr P Wilcox
Dr O Middleton
Dr E MacDonald
Dr E Mason

BILLINGSHURST SURGERY

PERMISSION TO DISCLOSE DATA

In accordance with the data protection act, the practice is not permitted to give information about a patient to a third party unless we have the patient's written permission.

On signing this form, please note that you have given consent for us to tell the named person(s) about past medical problems as well as current medical and future conditions. If there are any medical conditions you do not wish the person named below to be told about then you must notify us. The arrangement will continue until you notify us otherwise.

My Name:

My Date of Birth:

My Address:

I hereby give permission for Billingshurst Surgery to discuss information with the person(s) named below;

Name of Person_____

Address_____

_____

Relationship to Patient _____

Contact Phone Number(s) _____

Signature of Patient_____ Date_____

Admin use only

	Reminder added		R/C added		Initials