Hamilton Medical Centre

Patient Consent Form – Authority to Act (Third Party)

Dear Patient,

This form can be used if you wish to authorise another person to act on your behalf when communicating with the staff of Hamilton Medical Centre (HMC) regarding your care. This applies to anyone aged 14 years and over.

I (Name) _____ Date of Birth: _____ of (Address) _____ hereby give authority for the following person(s), to act on my behalf, in the areas ticked or crossed below:

Person 1

Name: _____ Date of Birth: _____

Relationship: _____ Contact Number: _____

Authority to: ☐ Cancel Appointments ☐ Receive results

☐ Update contact details ☐ Pick up prescriptions/referrals/requests/forms

☐ Make or receive other calls, enquiries or correspondence, with any other HMC staff

Person 2

Name: _____ Date of Birth: _____

Relationship: _____ Contact Number: _____

Authority to: ☐ Cancel Appointments ☐ Receive results

☐ Update contact details ☐ Pick up prescriptions/referrals/requests/forms

☐ Make or receive other calls, enquiries or correspondence, with any other HMC staff

Please complete the form below if you understand and agree to the following statements in relation to the disclosure of your patient information.

Consent

I, _____ have read the information above and understand that the information I have selected may be released or acted upon by my authorised person(s) as listed above. I understand that this authority can be withdrawn at any time either by verbal or written instruction.

Signature: _____ Date: _____

Decline Consent

I, _____ have read the information above and I ***do not*** give anyone permission to act on my behalf. I understand that this authority can be withdrawn at any time either by verbal or written instruction.

Signature: _____ Date: _____

PRACTICE USE ONLY:

Witnessed by (if applicable): (Staff signature) _____

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Entered onto BP: (Staff Name) _____ Date: _____