Cathedral Medical Group

Cawley Road, Chichester, PO19 1XT

Telephone: 01243 813450 Fax: 01243 813474

**Medical Information Third Party Disclosure**

**Details of the patient:**

|  |  |
| --- | --- |
| Name: |  |
| Date of Birth: |  |
| Address: |  |
| Email: |  |
| Home Number: |  |
| Mobile Number: |  |

I (Patient Name)………………………………………….. Hereby give authorisation for Cathedral Medical Group Surgery to discuss / disclose details of my medical information to;…………………………………………………. (Third Party).

**Third Party Details:**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Home Number: |  |
| Mobile Number: |  |
| Relationship to the Patient: |  |

Patient’s Signature:…………………………………………………………………………………..

Date:……………………………………………………………………

**THIS CONSENT WILL REMAIN ON YOUR RECORDS UNTIL YOU ADVISE US OTHERWISE**

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