THIRD PARTY ACCESS – ONE FORM PER 3RD PARTY

PATIENT DETAILS - Please write clearly

Surname	
First name	
Address + Postcode	
Date of birth	
Tele No	

I give consent for _____ to have the following permissions:
(please tick the appropriate box / es)

Make, Cancel and Alter Appointments on my behalf	
*Request / *Collect Medication on my behalf **Delete as appropriate**	
Discuss my current medical problems on my behalf	

THIRD PARTY DETAILS - VOUCHED
PHOTO ID MAY BE NEEDED (in person) SEEN

Surname	
First name	
Address + Postcode	
Date of birth	
Tele No	
Relationship to patient	

Signature of patient _____ Date _____

Signature of third party _____ Date _____

A member of the practice team may speak to the patient once the form is returned to verify this request if the patient does not attend with the third party on returning the form to the practice.