CONSENT FORM

If you wish to appoint a representative who may speak to the surgery on your behalf, please complete this form.

Please note that this form does not remove your right to make any changes to your record. We will monitor the use of your representative from time to time. We will also ensure that you are still the main contact to the surgery and fully involved in your medical care.

PATIENT'S Full Name: ……

Date of Birth: ……

Address: ……

Telephone: ……

I give consent for Inspire Health to discuss **all / some** aspects of my medical care with the person named below. (please circle all or some).

If you chose some, which aspects do you agree to? Please tick all that apply

- ☐ Book Appointments / change / cancel Appointments
- ☐ Order repeat prescriptions
- ☐ Request administrative documents such as letters, reports, clinical information about your medical care
- ☐ Other (Please specify below)

……

REPRESENTATIVE'S Full Name: ……

Date of Birth: ……

Address: ……

Telephone: ……

Signature of Patient: Date:

If we need to get in touch with you, who should we try to contact **first?**

Me ☐ My Representative ☐

Identity verified through **(tick all that apply)**	☐ **Self Vouching** ☐ **Vouching with information in record** ☐ **Photo ID** ☐ **Proof of residence** ☐ **Professional Vouching**
Name of Verifier	
Date of Verification	

Please note:

The patient giving consent for a representative must attend surgery with this form and valid identification.

If you cannot hand this form into surgery, we will need to contact you via telephone to confirm your identity and check that you filled in this consent form.

If you wish to remove the representative from being able to speak on your behalf, please contact us as soon as possible.