THORNBURY HEALTH CENTRE

STREAMSIDE SURGERY

Eastland Road

Thornbury

Bristol

BS35 1DP

**CONSENT TO SHARE MEDICAL INFORMATION**

Patient Name: ……………………………………………….

Date of Birth: ……………………………………………….

I hereby give consent for my:

- test results (blood tests, x-rays, us scans, etc)

- doctors/nurses appointments

- prescriptions/medication

- medical details

- any other information pertinent to my medical care

(delete as appropriate)

to be discussed with the following named people:

Name Relationship to Patient Contact Details

Signature of Patient: ……………………………………………… Date: …………………

MSWDocs/Standard letters/ Consent to share Details