**ASHINGDON MEDICAL CENTRE**



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**CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION**

|  |  |
| --- | --- |
| **Name:** | **DOB:** |
| **Address:** |
|  |
| **Telephone Number:** |

I hereby consent for your staff to give the agreed information to person / people detailed below:

|  |  |
| --- | --- |
| **Name:** | **DOB:** |
| **Relationship:** | **Tel:** |
| **Address:** |
|  |

Please tick as appropriate:

 To give out my results only

 To discuss all medical information

 This authority is to remain valid until such time

 This authority is valid from \_\_\_\_\_\_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_\_\_\_\_

 SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_