FOR OFFICE USE PATIENT NO:

CONSENT TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO A THIRD PARTY

I	
Of	
D.o.B.:	
Telephone:	

give my consent to the release of confidential information from my medical records as follows:

Please give the name and address of the person or organisation you wish the information to be given to:	
Please describe what information you want released: (e.g. details concerning headaches, all hospital letters, my physiotherapy reports, etc)	
Please indicate if you wish to see the report before it is sent or not:	☐ I DO NOT WISH TO SEE ☐ I WISH TO SEE

I understand that this consent is **enduring**, unless I give written notification otherwise.

Signed:	
Date:	

Please return this form to the University Health Service

Dr Sarah J R Armstrong Dr Suzy C Bannister Dr Mark Edwards Dr Christopher J James Dr Heather N Wilson
Practice Manager: Mrs. Wendy Fielder
www.unidocs.co.uk