Ivel Valley South PCN
blmkicb.carecoordinator.ivs@nhs.net

Consent to Share Medical Record with a Nominated Individual

I agree to:

☐ **I _____ Date of birth _____ give permission for the following people to discuss all aspects of my medical care with the Primary Health Care Team**

Name	Realtionship to patient	Contact details

Giving consent to someone else to share your medical record enables that specifically named individual to communicate with Ivel Valley Primary Care Network on your behalf. This can include but is not limited to: appointment bookings, medications, referrals and results.

You should note that once you give this consent the named individual can access all the information contained within your record past and present.

I accept responsibility that if I wish this consent to be removed, I will inform Ivel Valley South Primary Care Network and the surgery that I am registered with

Full name

Date

Signature