CONSENT FOR 3rd PARTY ACCESS – DINGWALL MEDICAL GROUP

NAME	
DATE OF BIRTH	
ADDRESS	

I hereby consent to;

Name: _____

Address: _____

_____

Relation to Patient: _____

Date of Birth: _____

Mobile Contact No.: _____

Having access to my:	Please tick all that apply:	How long for? 1 month, 6 months or 1year
Appointment times		
Blood results (by phone only)		
Prescription queries		
Other (please specify)		

Signed: _____ Date: _____