Patient Affairs Consent Form

Before confidential information can be disclosed to a third party, this form needs to be completed and returned by the Patient/Service User (aged 12 & over) or their Next of Kin (NoK), if the Patient/Service User is unable to give their consent.

Section 1 – Patient Details (PRINT)	
Title	
Name	
Address	
Telephone Number	
Email Address	
Date of Birth/ CHI number (if known)	
Summary of issue	
Section 2 – Details of the person information is to be shared with (PRINT)	
Title	
Name	
Address	
Telephone Number	
Email Address	*By providing an email address, you are agreeing to receiving communication by email*
Relationship to patient	
Section 3 - Statement by the Patient or the NoK, where Patient is unable to consent. Please tick Part A (Patient) OR Part B (NoK) as appropriate.	
Part A - I am aware the person detailed in **Section 2** has requested a response, which requires the review and disclosure of my personal information **about the specific issues noted above**. Accordingly, I hereby give my consent for the disclosure of this information.	
Patient's signature	**Date**
Part B - I am the NoK. The patient is unable to give consent.	
NoK Name (PLEASE PRINT)	
NoK Signature	**Date**
Relationship to patient	
Reason patient cannot provide consent	

Please enclose a copy of the Welfare Power of Attorney or Guardianship if relevant

Please contact Patient Affairs if you wish to withdraw consent at any point