

**Patient consent for third party**

Patient name­-

Date of birth -

I give permission for ………………………………… (insert third party name)

to discuss matters concerning …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

And I give permission to Town Gate Practice to release only relevant information relating to matters detailed above.

Signed -

Date-

If the patient is unable to sign this consent form please complete this section. Requests under this category will be considered on an individual basis.

(Name of patient) …………………………………is unable to sign this consent form because …………………………………………………………………………………………………………

Signed -

Date-

Relationship to patient-