# CONSENT FORM

**This form is only valid if completely filled in**

Surname: V / M / X

Initial(s)/ first name:

Date of birth:

Address:

Phone number(s):

Signature: Date: Place:

**By signing this form, the aforementioned patient voluntarily agrees that medical information may be provided on request to:**

Name: Date of birth:

Relationship with patient:

*2nd person (if applicable):*

Name: Date of birth:

Relationship with patient:

**Please tick below what you consent to:**

- Requesting medical results
- Collection of letters/medical referrals
- Consultation with a care provider if the GP cannot reach me
- Requesting information from my file
- Calling the practice on my behalf, e.g. to inquire when you have an appointment or what policy has been agreed to

**Without your consent, we do not provide any medical data but to yourself. You can revoke this consent at any time. This consent form remains valid until you indicate otherwise.**