

ST LUKE'S PRIMARY CARE CENTRE

CONSENT FORM

I (patient) give my consent for St Luke's Primary Care Centre to discuss my medical care (*e.g. medication, test results, referral letters, appointments etc.*)

with (*name of person being given consent*):.....

who is my (*relationship to patient*):.....

(e.g. partner, spouse, daughter, father).

I am aware that this information will be added to my medical records and that it is my responsibility to advise the practice if I withdraw this consent at any time.

Patient Name:.....

Date of Birth:.....

Relation's contact details:.....

.....

.....

Signed:.....

Date:.....