Braids Medical Practice

Data Protection Act

In accordance with the above act the practice needs your consent before we can give out any information regarding yourself to a third party. We would be grateful if you would complete this form giving us details of whom you would wish any results, or any other aspects of your medical records given out to.

I (Signature)---------- D.O.B ----------
authorise the person named below to obtain any information on my behalf from Braids Medical Practice.

Authorised Person----------

I **do not** authorise any information to be given to anyone other than myself

Signature----------

This form will be kept in your medical records

Date----------

Dr Lindsay Burgess Dr Helen Horsfall Dr Nick Payne
Dr Mark Stevenson Dr Bethan Townend Dr David Walker

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