Victoria Cross Surgery & Eldene Health Centre

CHOOSING WHICH ORGANISATIONS CAN VIEW YOUR MEDICAL RECORDS

Having read the information sheet, please choose ONE of the following options below and send/email/hand it to reception or to any member of the practice staff

1. SHARING INFORMATION FROM YOUR GP RECORDS

Do you consent to the sharing of data recorded here with any other healthcare organisations also caring for you?

- ***YES*** *– share data with other organisations with no additional security** *(tick box)* ☐

OR

- ***YES*** *– share data with other organisations, but I wish to provide additional security, and I confirm that I have provided the practice with a mobile telephone number and an email address, and that I will ensure that the practice is notified if either of these details change** *(tick box)* ☐

OR

- ***NO*** *– do not share any data recorded here with any other organisation providing me with healthcare* *(tick box)* ☐

**** Please see the attached leaflet for further information***

AND

2. SUMMARY CARE RECORD ("the Spine")

Having read the information sheet, please choose ONE of the following options below and send/email/hand it to reception or to any member of the practice staff.

A. Yes I would like a Summary Care Record – *express consent for medication, allergies and adverse reactions only.* *(tick box)* ☐

OR

B. Yes I would like a Summary Care Record – *express consent for medication, allergies and adverse reactions* ***and*** *additional information* *(tick box)* ☐

OR

C. No – I would not like a Summary Care Record *(tick box)* ☐

Personal Details on page 2 MUST be completed

PERSONAL DETAILS – <u>FORMS WHERE THIS SECTION IS BLANK WILL NOT BE ACTIONED</u>

A. Please complete in BLOCK CAPITALS

Title: _____ Surname / Family name: _____

Forename(s): _____

Date of birth: ___ / ___ / ___ NHS No. (if known) _____

Address: _____

_____ Postcode: _____

Phone No: _____ Mobile No: _____

Signature _____ Date: ___ / ___ / __

B. If you are filling out this form on behalf of another person or child please ensure you fill out their details in section **A.** and your details in section **B.**

Your name: _____ Your signature: _____

*Relationship to patient: _____ Date: ___ / ___ / ___

**In signing, you are confirming that the patient is (a) a minor; (b) lacks capacity to make the decision, or (c) that you have their consent to complete the form on their behalf.*