

# Woosehill Medical Centre

Fernlea Drive, Woosehill, Wokingham, RG41 3DR  
Tel: (0118) 978-8689 www.woosehillsurgery.co.uk

## CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Name: ----- Date of Birth:-----

Address: -----

I hereby consent to the disclosure of my private medical information to:

Name: ----- Date of Birth:-----

Relationship:----- Tel. No.-----

Address:-----

**Please tick the statement/s applicable:**

Full and open ended disclosure of any matter related to my medical record

Full disclosure of any matter related to my medical record for the period

(From)----- (To)----- (not applicable to 11 to 15 year olds)

Limited disclosure of the following aspects of my medical record:

- Test Results
- Prescription queries
- Referral queries
- Referral queries

Any other matter related to my medical record, please state:-----

**I am aware that this consent may be revoked by me at any time.**

**Please note: If you are between the age of 11 and 15, it will be your responsibility to notify the surgery when you turn 16 to switch the consent off if necessary.**

Signature:----- Date:-----

**If you need assistance in completing this form please ask the Receptionist.**

Dr Rishi Anand, Dr Sanveer Tiwana, Dr Kike Amira  
Operations Manager – Rowena Beech, Business Support Manager – Chris Allen