BEAUMONT ELMS
PRACTICE

CONFIDENTIALITY WAIVER

I, the patient (please print name) ……..

D.O.B: ……..

Give my permission that details concerning **all** of my medical treatment may be given to

(Please print name) ……..

Contact Details:……..

Relationship……

I understand that if the practice contacts me using the details provided the above named authorised person may accept information on my behalf.

On contacting the practice, the above named person will inform the receptionist immediately that we have a confidentiality waiver, and we understand that the receptionist will need to take time to view it before entering into any conversation regarding my medical information.

I give permission for this document to be added to my medical records. The waiver will enable the practice to discuss my medical information from the date it is signed.

I therefore waive my rights to confidentiality as described above and understand that no member of staff (administrative or clinical) at Beaumont Elms Practice will be held responsible for any such disclosure to the above named person.

Signed (Patient):……

Signed(authorised person):……..

Date: ……..