NEWFIELD MEDICAL GROUP

PATIENT CONSENT TO ALLOW ANOTHER PERSON TO ACT ON YOUR BEHALF

Please complete this form if you wish to authorise another person to act on your behalf in relation to certain aspects of your care and communication with the practice.

Please note, this form **does not give another person legal decision-making authority** over your healthcare. The practice will only share information that is **necessary and appropriate**. Practice staff may refuse to disclose information where there are concerns regarding confidentiality, safeguarding, capacity or where disclosure would not be appropriate. You may withdraw your consent at any time by contacting the practice in writing. This consent is **valid for 12 months only** and will automatically expire unless renewed.

Patient Details:

Full Name	
Date of Birth	
Address	
Telephone Number	

Details of Person Authorised to Act on Your Behalf:

Full Name	
Relationship to Patient	
Telephone Number	

Patient Declaration:

I understand that confidential information may be shared with the above named person who I have authorised to act on my behalf. I understand this consent **does not provide legal decision-making authority** and may be declined where appropriate under confidentiality, safeguarding or legal obligations. I understand that this **consent expires after 12 months and requires renewal**

Patient Signature: ____ Date: ______________

Practice Use Only:

Date Received	
Staff Member	
Consent Expiry Date	
Alert Added to Vision (detailing person authorised & expiry date)	
Scanned to Docman	