ILKLEY & WHARFEDALE
MEDICAL PRACTICE

Consent Form for Access to Medical Records and/or Test Results

Only To Be Completed By Patients 12 And Over.

Please accept this form as consent for my relative/carer named below to have access to my:

Medical Records	Yes	No	Please circle as appropriate
Test Results	Yes	No	Please circle as appropriate
Speak to the Ilkley & Wharfedale Medical Practice staff on my behalf	Yes	No	Please circle as appropriate
Online access to summary records/results/appointments	Yes	No	Please circle as appropriate

Name (patient) .....

Address (patient) .....

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Telephone (patient) .....

Date of Birth (patient) .....

Signature (patient) .....

Name of Relative/Carer .....

Relationship To Patient .....

Telephone (relative/carer) .....

Signature (relative/carer) .....

Date .....