Consent to Share Patient Information

Do you consent to information about yourself and/or your care being shared with others involved in your care?

If so, please specify:

Husband *Wife* *Son* *Daughter*

Sister *Brother* *Friend* *Carer*

Please print the person's name with whom you wish to share your information:

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Is there any specific information you would not wish to be shared?

.....

Reason for consent being given:

.....

Print Name .....

Signed .....

Date .....