WELLINGTON
Medical Practice

Carer - Patient Consent Form

If you are a carer (paid or unpaid) for a friend or a family member and would like this to be recorded in our records, please complete the form below with your details as well as the person you care for details.

Patient Details

Name	Date of Birth
Address	
Post Code	Telephone Number

Carer Details

Name	Date of Birth
Address	
Post Code	Telephone Number
I consent to being identified as a carer for the above named person. Signed	Date

Consent from the person being cared for:

I agree that the person named above is my carer and I consent to this information being recorded in my medical records.

I also consent to my medical information being shared with the person named above when necessary **YES/NO (please delete as appropriate)**

Signed **Date**

Please note: - All patients will be contacted to verify consent, when the form is received in the practice.