**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.<br>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.**