Marsh Medical Practice

Third Party Consent Form

I (*patient name*)……. give consent for Marsh Medical Practice to

- discuss my confidential health information with *(delete if not applicable)*
- investigate a complaint made by *(delete if not applicable)*

the person named below and that they are acting with my authority when making any requests.

Name: ……

Address: ……

……..

Relationship to patient: ……

I understand that this may include copies of all medical records and letters that Marsh Medical Practice hold and may include sensitive and confidential information.
Any information will be sent directly to the person requesting the information, unless Marsh Medical Practice are advised in writing.

Patient signature: ……

Date of birth: ……

Address: ……..

……..