GENERAL PRACTITIONER (GP) CONSENT FORM

Patient Name: _____ Date of Birth: _____

Patient Information:

Address: _____

Phone Number: _____

Email: _____

GP Practice Details:

GP Name: _____

Practice Name: _____

Practice Address: _____

Practice Phone Number: _____

Consent Details:

I hereby consent to the release of my medical records and relevant health information held by my General Practitioner (GP) to the requesting party. I understand that this information will be used for the purposes stated and will be handled confidentially in accordance with UK data protection laws, including the Data Protection Act 2018 and UK GDPR. I acknowledge that I have the right to withdraw this consent at any time by notifying my GP practice in writing.

Scope of Information to be Disclosed:

This consent covers all relevant medical records including but not limited to diagnoses, treatment plans, test results, prescriptions, referral letters, and consultations pertinent to my care. It excludes any information that is not directly related to the purpose of this disclosure.

Purpose of Disclosure:

The purpose of this disclosure is to facilitate continuity of care, enable assessment or treatment by other healthcare professionals, or any other lawful purpose that I have explicitly authorised.

Duration of Consent:

This consent is valid until it is revoked by me in writing. Revocation does not affect any disclosures made prior to such revocation.

Data Protection and Confidentiality:

My personal data will be processed in compliance with the Data Protection Act 2018 and UK GDPR. The receiving party is required to maintain confidentiality and take all reasonable steps to protect my information from unauthorized access, loss, or disclosure.

Acknowledgement and Signature:

I confirm that I have read and understood the terms of this consent form. I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily agree to the sharing of my medical information as outlined above.

Patient Signature:

Date: _____

GP/Practice Representative Signature:

Date: _____