ADULT - Medical Record Sharing Consent

(Please note: Patients registering with the Practice for the first time will have these options automatically set to implied consent if this form is not completed)

Patients Full Name: ..... Patients DOB: .....

I do want a Summary Care Record	☐
I do NOT want a Summary Care Record	☐

I do want my SystmOne Electronic Patient Record (Surgery record) shared with community services (e.g. Physio, Community Diabetes) and Your Care Connected	☐
I do NOT want my SystmOne Electronic Patient Record (Surgery record) shared with community services (e.g. Physio, Community Diabetes) and Your Care Connected	☐

I do want community services (e.g. Physio, Community Diabetes) information shared with my GP	☐
I do NOT want community services (e.g. Physio, Community Diabetes) information shared with my GP	☐

Signature ..... Date .....

If you attend a community service (e.g. Physio, Community Diabetes, Community Respiratory) you will also need to advise **them** that you are happy to share the information they hold with us.