



CHILD - 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 created for this patient | <input type="checkbox"/> |
| I do NOT want a Summary Care Record created for this patient | <input type="checkbox"/> |

| | |
|--|--------------------------|
| I do want this patient's Systm One Electronic Patient Record (surgery record) shared with community services (e.g. Physio, Community Diabetes) and Your Care Connected | <input type="checkbox"/> |
| I do NOT want this patient's Systm One Electronic Patient Record (surgery record) shared with community services (e.g. Physio, Community Diabetes) and Your Care Connected | <input type="checkbox"/> |

| | |
|--|--------------------------|
| I do want community services (e.g. Physio, Community Diabetes) information shared with this patient's GP | <input type="checkbox"/> |
| I do NOT want community services (e.g. Physio, Community Diabetes) information shared with this patient's GP | <input type="checkbox"/> |

Signature on behalf of Child _____ Date _____
Parent / Carer's name _____ I have parental responsibility
(We cannot action requests if parental responsibility is not held)

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.