Dr. D. Sykes
Dr. H. Pelc
Dr. K. Gascoyne
Dr. S. Worsnop
Dr. C. Liley
Dr. K. Argyle
Dr. A. Ahmed

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Marsh Avenue
Hope
Hope Valley
S33 6RJ
01433 621557
ddicb.admin.emc@nhs.net

Third Party Consent Form

Patient Information	
Full Name:	**Address:**
Date of Birth:	

Nominated Third Party Information	
Full Name:	**Address:**
Relationship to Patient:	
Telephone Number:	

Nominated Third Party Information	
Full Name:	**Address:**
Relationship to Patient:	
Telephone Number:	

Nominated Third Party Information	
Full Name:	**Address:**
Relationship to Patient:	
Telephone Number:	

Declaration	
I, the undersigned, wish to give my permission for my nominated third parties, as stated above to be contacted by the Evelyn Medical Centre and discuss (tick as appropriate): • Anything in my medical records, including appointments ☐ Or • Appointments only but no medical details – Confirming appointments with the practice, making appointments, cancelling appointment etc. ☐	
I, the undersigned, understand that this decision will apply unless I inform the practice otherwise.	
Full Name:	**Date:**
Signed:	