New Dyce Medical Practice

Scotstown Medical Group

GENERAL DATA PROTECTION REGULATION

☐ In line with General Data Protection Regulations we cannot discuss or share information regarding your medical wellbeing with your relatives, partner or carer without your prior consent. If you agree to this information being shared with these individuals please give your consent below. **I,**

Your name: _____ Date of Birth: _____

Your address: _____

_____

Home No: _____ Mobile No: _____

Work No: _____

Email address: _____

consent to information from my medical records at New Dyce Medical Practice being shared with the undernoted people. This information may include test results and messages regarding future appointments at the practice.

Name: _____ DoB: _____

Relative – please specify ☐ Partner ☐ Carer ☐

Name: _____ DoB: _____

Relative – please specify ☐ Partner ☐ Carer ☐

I consent to the following method/s being used to contact me (please tick box)

Home no:	☐	Mobile no:	☐	Work no:	☐
Text msg:	☐	Letter:	☐	Email address:	☐

I, also consent to you identifying yourself as New Dyce Medical Practice when you leave a message via the above method: Yes ☐ No ☐

Nb: If you do not respond to our messages via your preferred method we will automatically default to sending you a letter on our third attempt.

Patient Signature _____

If your personal circumstances change and you no longer consent to the above information being shared please inform the Practice in writing.