**Patients Name**  ...........................................................................................

**Address** ...........................................................................................

 ...........................................................................................

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**Date of Birth** ...........................................................................................

**I confirm that I authorise the named person(s) to communicate with the practice on my behalf regarding my appointments, results, and any other information in relation to my health care.**

**Full Name** ...........................................................................................

**Relationship**  ............................................................................................

**To Patient**

**Contact Number (s)** ............................................................................................

**Full Name** ...........................................................................................

**Relationship**  ............................................................................................

**To Patient**

**Contact Number (s)** ............................................................................................

**Consent to be given until withdrawn by me in writing.**

Signed ............................................................................... Date ........................................