Rothschild House Group

All correspondence to:
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Chapel Street, Tring
HP23 6PU

t: 01442 822 468
w: rothschildhousesurgery.co.uk

PATIENT CONSENT FORM
(the releasing of medical information to an appointed person)

Name of Patient: _____

Date of Birth: _____

Address: _____

_____

_____

Tel. No: _____

Date: _____

Signature: _____

I hereby consent to any medical information concerning my medical history being given to the following relative/friend/carer:

Thank you.

1. Name: _____ Tel. No.: _____

   Email Address: _____

   Relationship to Patient: _____

2. Name: _____ Tel. No.: _____

   Email Address: _____

   Relationship to Patient: _____

Please return to your surgery