**FORM OF AUTHORITY**

|  |  |  |
| --- | --- | --- |
| **Patients Name** | **First Name** | **Surname** |
| **Address:** |  | **Postcode** |
| **DOB** |  **/ /** |

**I fully consent to the Person(s) named below to be able to discuss my Healthcare and medical information on my behalf, including results and prescriptions.**

|  |  |  |
| --- | --- | --- |
| **Name of Nominee** | **Relationship to Patient** | **Contact Number (s)** |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |

|  |  |
| --- | --- |
| **Patient Signature** |  |
| **Nominee(s) Signature**  |  |  |
|  |  |
| **Date** |