**CONSENT FORM**

Name: ………………………………………………………………………………………….

Date of Birth: …………………………………………………………………………………..

Address: ……………………………………………………………………………………….

…………………………………………………………………………………………………..  
I give permission for the following person/s:

Name: ………………………………………………………………………………………….

Relationship:

Mother  Father  Daughter  Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

Other (please specify) …………………………………………………………………….

Name: ………………………………………………………………………………………….

Relationship:

Mother  Father  Daughter  Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

Other (please specify) …………………………………………………………………….

Name: ………………………………………………………………………………………….

Relationship:

Mother  Father  Daughter  Son ☐ Husband ☐ Wife ☐ Friend ☐ Carer

Other (please specify) …………………………………………………………………….  
To be able to do the following on my behalf at Belmont Health Centre (Dr J J Wijeratne & Partners) :

Book appointments  Cancel appointments

Request prescriptions  Collect prescriptions

Surgery to leave messages with this person relating to myself  Check test results

I understand that it is my responsibility to inform the surgery if the above information changes in the future.

Signature: ……………………………………………………………………………………

Date: ……………………………………………………………………………………………