**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: ……………………………………………………………………………………………