



Partners: Dr R Liddell MB ChB FRCGP DRCOG  
 Dr K Duthie MB ChB Dip Obs (NZ)  
 Dr P Guthrie MB ChB DRCOG  
 Dr S Henderson MB ChB MRCGP DRCOG  
 Dr K McLuckie MB ChB MRCGP DPD  
 Dr C Lawson MB ChB MRCGP DRCOG

Email: turriff.administrator@nhs.net

**Turriff Health Centre Balmellie Road Turriff AB53 4DQ Tel. 0845 337 6320 Fax. 01888 564010**

**CONFIDENTIAL PATIENT INFORMATION**

**CONSENT FORM TO ALLOW ANOTHER PERSON TO ASK FOR RESULTS/INFORMATION  
ON BEHALF OF A PATIENT**

|   |  |                           |
|---|--|---------------------------|
| Patients Name:  |  | (Print in Block Capitals) |
| Patients DOB:   |  |                           |
| Patients Address:<br>(Please print in Block Capitals) |  |                           |

I hereby give consent that the person named below is allowed to ask for results and other information on my behalf:

Signature of Patient:

|   |  |                           |
|---|--|---------------------------|
| Name of Proposed Person:  |  | (Print in Block Capitals) |
| Relationship to Patient:  |  | (Print in Block Capitals) |
| Address of Proposed Person:<br>(Please Print in Block Capitals) |  |                           |
| Signature of Proposed Person:                                   |  |                           |

|        |  |
|--------|--|
| Dated: |  |
|--------|--|

**TO PATIENT – PLEASE FILL IN ALL THE DETAILS ABOVE AND RETURN TO RECEPTION AS SOON AS POSSIBLE SO THAT WE CAN ARRANGE FOR THIS.**