



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: (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: (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.