Great Chapel Street Medical Centre

13 Great Chapel Street, Soho, London, W1F 8FL

Telephone: (020) 7437 9360
(020) 7439 2389
Fax: (020) 7734 1475

AUTHORISATION TO DISCLOSE INFORMATION

It would assist your doctor if you would sign the authorisation below. Your signature of authorisation will be used by the doctor to obtain information about your medical history.

All information obtained will be dealt with confidentially.

NAME ----------

DOB ----------

ADDRESS ----------

I, the undersigned, agree to any information on my medical history being disclosed to my doctor.

I also authorize Great Chapel Street Medical Centre (GCS) to act on my behalf and in my interest (including liaising with external agencies) in relation to my medical and social care needs specific situation and related issues.

In giving this permission, I understand that the information will be held in accordance with GCS's confidentiality policies (including the Data Protection Act 1998 and The Caldecott Guidelines) and that I have access to any information about me that is held on file or computer.

The Caldecott Guidelines: 1) The use of patient information must be justified; 2) Patient identifiable information must only be used when absolutely necessary, and the use must be the minimum necessary; 3) Access must be on a "need to know basis; and 4) everyone must be aware of their responsibilities and comply with the Data Protection Act.

I am aware that this letter of authorisation will be photocopied and have agreed that copies may be used to obtain information.

Signed ----------

Date ----------