



Formerly East Leake Medical Group & Keyworth Medical Practice

Consent Form

Name of Patient:

Registered Branch:

Address:

Date of Birth:

I,, give consent for the Doctors and Staff at Village Health Group to discuss:

Please circle the below options as appropriate

[1. My Medical Record]

[3. My Online Detailed Coded Record]

[2. My Online Medical Record]

[4. My Online Full Clinical Record]

Please put a strike through any uncompleted row below

Name	Relationship	Contact Number

Please be advised if this form has been completed and handed back to the surgery, the team may still need to make contact with the consenter to verify identity and to check the details of the consented.