**St Luke’s Primary Care Centre**

**CONSENT FORM**

I give my consent for St Luke’s Primary Care Centre to discuss my medical care (e.g. medication, test results, referral letters, appointments etc.) with:……………………….……………………………. who is my:………………………………………………… (eg partner, spouse, daughter, father).

I am aware that this information will be added to my medical records and that it is my responsibility to advise the practice if I withdraw this consent at any time.

Name:………………………………………………………………..

Date of Birth:…………………………………………………………

Contact number:…………………..………………………………

Signed:…………………………………………………………………….

Date:………………………………………………………………………..