KENNEDY WAY SURGERY

Kennedy Way, Yate, S.Glos, BS37 4AA
Telephone: (01454) 313849 (day and night)
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13 to 15 Year Old Parent/ Guardian Consent Form

Patient's Name:	
Patient's Date of Birth:	
Patient's Address:	
Patient's Contact Number:	

I give authority to,_____ to do the following actions on my behalf:

Have access to my medical records:	
Discuss my medical needs:	
Book and confirm consultations of my behalf:	
Attend consultations with me:	
Obtain results on my behalf:	
Order prescriptions on my behalf:	
All of the above:	

I understand that I can change and revoke access to any of the above at any time.

I understand that this consent only remains in place until my 16th birthday and at that point it becomes invalid.

Signed:						
Please print your full name here:						
Date Signed:						

If this form is not handed in by the patient that is giving consent, we will contact them on number listed on their medical records to check authorisation with them

Office Use:

Form Received By:	
Confirmed handed in by the patient giving consent by:	
Patient giving consent contacted and consent confirmed by:	