

Information Sharing Consent Form

Please see information display or ask for a leaflet at reception for details.

Summary Care Records

Please tick this box if you DO NOT want a Summary Care Record.

GPES

Please tick this box if you DO NOT wish for anonymous information to be used for research.

eDSM

➤ Share-out

I **would*** / **would-not*** like the information recorded at Barnby Gate Surgery to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

➤ Share-in

I **would*** / **would-not*** like the information recorded at other care teams who are involved in my care to be seen by members of the team at Barnby Gate Surgery, where I have granted those care teams the right to add to my shared data.

** Delete as appropriate*

I understand that I can change my decision on any sharing consents at any time.

Patient Name:	
Patient Date of Birth:	
Patient Signature:	
Today's Date:	

If signing on behalf of someone else:

Patient representative:	
Relationship to patient:	