BLACKBUTT
DOCTORS SURGERY
Quality healthcare made simple

BLACKBUTT DOCTORS SURGERY
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Change to Third Party Consent for Patients of Blackbutt Doctors Surgery

I (Name):______________________________________ Date of Birth:___________________________

Of (Address):____

Request the following changes/removal (cross out whichever is not applicable) to third party consent for:

Name:____

Address:____

Phone:______________________________________ Date of Birth:_____________________________

- ☐ Not authorised to take calls
- ☐ Not authorised to receive results
- ☐ Not authorised to make, confirm, change or cancel appointments
- ☐ Not authorised to access and request copies of my file
- ☐ Not authorised to collect and request letters, request for pathology and forms etc.
- ☐ Not authorised to make or receive any other enquiries or correspondence from any Doctor, Nurse or Administrative staff member at Blackbutt Doctors or Our Town Doctors Surgeries.

I understand that until I receive written confirmation from the surgery that these changes to third party consent will not be in effect.

Patient Name:_______________________________________ Date:_____________________________

Signed:____