**Patient Records**

**Third-Party Consent Form**

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| --- | --- |
| **Patients Name:** |  |
| **Patient’s Date of Birth:** |  |
| **Patient’s Address:** |  |
| **Request made by:** |  |
| **Relationship with patient:** |  |
| **Requestor Telephone Number:** |  |
| **Requestor Address:** |  |

**If you are requesting information on behalf of a patient then consent of the patient will be required. Please obtain the patient’s signed consent below.**

I fully consent to Connect Health releasing information to, and discussing my care and medical records with the individual named above. and I agree that Connect Health may disclose to them (only insofar as is necessary) confidential information about me.

**Signed:**……………………………..(Patient)

**Full Name**: …..............................

**Date:**…………………………………