**THE GLENFIELD SURGERY**

**FORM OF AUTHORITY**

**PATIENT’S NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I fully consent to the person(s) named below discussing my care and medical information on my behalf, including results and prescriptions.***

|  |  |  |
| --- | --- | --- |
| **NAME OF NOMINEE** | **RELATIONSHIP TO PATIENT** | **CONTACT NUMBER(S)** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

**PATIENT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOMINEE/S SIGNATURE:** 1.\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_ , ­­­­­­­­­­­­­­­3.\_\_\_\_\_\_\_\_\_ , 4. \_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_