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 :_____

_____

DATE: _____