Sharing of Information Form

Patient Name: ………………………………………… **D.O.B:** ……………………………………………

I, the above patient of SB Physiotherapy, give my consent for my health records to be shared in connection with my care with (please specify and add details as appropriate):

- My next of kin or family members

  Please Specify:
  ………
  ………

- My Insurance Company ☐
- Other Referrer ☐
- Other (please specify) ☐

  ………
  ………

  When sharing information about you our staff use the following principles as set out in the General Data Protection Regulation 2018.

- Only share information with those who need to know in order to provide good quality care.
- Share the minimum information necessary to ensure the good quality care.

Signature……………………………………… Print………………………………………………

Date……………………………………………

If filling in this form on behalf of a patient:

Name: ………………………………………………. Relationship to patient: …………………………......

Reason for filling in form on their behalf: ………………………………………………………………….