WOODINGDEAN MEDICAL CENTRE

WARREN ROAD, WOODINGDEAN
BRIGHTON, EAST SUSSEX BN2 6BA
Tel: 01273 30755 I Fax: 01273 304861

CARER'S AUTHORISATION FORM

I hereby give authorisation for details of my medical care and record to be shared with my carer.

Carer's name ………………………………………………………………………………………

Carer's address (inc postcode) ……………………………………………………………...

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Carer's date of birth…………………………………………………………………………….

Carer's phone number……………………………………………………..…………………..

Their relationship to patient…………………………………………………………………

Signed ………………………………..…. Name (please print)…………………………………

Date of authorisation ………………………………………………………………

TO AUTHORISE A 2ND CARER PLEASE FILL OUT THE SECTION BELOW

Carer's name ………………………………………………………………………………………

Carer's address (inc postcode) ……………………………………………………………...

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Carer's date of birth…………………………………………………………………………….

Carer's phone number……………………………………………………..…………………..

Their relationship to patient…………………………………………………………………

Signed ………………………………..…. Name (please print)…………………………………

Date of authorisation ………………………………………………………………