Ivy Grove Surgery

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CONSENT TO ACCESS MEDICAL RECORDS ON BEHALF OF A PATIENT

I hereby give consent for my _____ (relationship to patient)

_____(name of person needing access)

to have full access to my medical records. I understand that I can revoke this consent at any time by applying in writing.

Signature _____

Name _____

Address _____
_____
_____
_____

Date _____