Consent to Share and Leave Messages

My Details	
Full Name:	
Date of Birth:	
Address:	
Email Address:	

I give consent for Living Well Partnership to leave messages on my answer phone at the following numbers:

Contact Number:	Home	Work	Mobile	Other
1 -	☐	☐	☐	☐
2 -	☐	☐	☐	☐
3 -	☐	☐	☐	☐
4 -	☐	☐	☐	☐

I give consent for Living Well Partnership to:

☐ Leave messages about any aspect of my medical treatment

☐ Discuss medical matters

with the following third parties:

Name:	Relationship	Contact number
1 -		
2 -		
Can these people pick up prescriptions on your behalf? ☐ Yes ☐ No		
Signed:	Printed:	

If you want your consent to cease, please contact a receptionist. An acknowledgement of your cease to consent will be sent you at the address we

Communication Preferences

Can you confirm how you would like us to contact you and tell us which is your **preferred** way to be contacted.

Email	☐ Yes	☐ No	I prefer to be contacted this way ☐
Text	☐ Yes	☐ No	I prefer to be contacted this way ☐
Letter	☐ Yes	☐ No	I prefer to be contacted this way ☐
Telephone	☐ Yes	☐ No	I prefer to be contacted this way ☐

Blood results by text: I would like to receive any test results by text: Yes ☐