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**Information Sharing Consent Form**

To assist Community Medical Solutions Ltd (CMS) to provide optimal medical care during your visit to our service it is important the doctor is able to see your medical history. They will use this information to make sure there is nothing in your past medical history that could suggest the procedure you seek is not suitable or unsafe for you or possible complications more likely? In order to see your records we first need your consent. It is your choice to allow access to your records. If you do not wish for your records to be shared with us then instead you will need to obtain a full summary of your medical history from your GP and provide this before we can proceed. If you do consent to sharing your records then once you have finished treatment with CMS your care will be ended and we will then have no continued access to your records.

**Your consent to share personal information is entirely voluntary and you may withdraw your consent at any time.** Should you have any questions about this process, or wish to withdraw your consent please contact the medical secretary team on 01908 619912.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby give my permission for my personal information to be shared with Community Medical Solutions Ltd (CMS) in connection with my care, including accessing and sharing my medical records. I understand that CMS may hold information gathered about me and as such my rights under the Data Protection Act 2018 will not be affected.

**Statement of Consent:**

* I understand that personal information is held about me.
* I have had the opportunity to discuss the implications of sharing or not sharing information about me.

I agree to my information being shared and gathered between the above services

**Name …………………………………………………………………..……………. Date of Birth …………………………..**

**Address ………………………………………………………………..........................................................**

**Post code ……………………**

**Signature ………………………………………………**

**Date ………………………**