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**PATIENT CONSENT FORM**

I …………………………………………. give consent for my …………………………………………….(relationship)

…………………………………………….(full name)

to have access to my medical records and for you to discuss my medical records with him/her.

Signed…………………………………

Dated…………………………………..

Print name………………………………………………..................

Date of birth..............................................................................

Address……………………………………………………………….……………………………………………………………………………………………………………………………………………………………………………………..Postcode…………………………….

Please provide below, a contact number for the person for whom you have given consent:

Home telephone……………………………………………………

Mobile telephone……………………………………………………

Grantham Road, Navenby, Lincoln LN5 0JJ. Tel: 01522 811411 Fax: 01522 813835