Consent to Share and Leave Messages

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 -	☐	☐	☐	☐

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:

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 ☐

NEW: We would like to send you test results & important notifications by text:

I would like to receive important clinical information by text: Yes ☐

Patient Participation Group

We would like to invite you to join our Patient Participation Group. The aim of this group is to advise the practice from a patient perspective and provide insight into the responsiveness and quality of services we provide. The group also encourages other patients to take greater responsibility for their own and their families health.

We hold meetings 4 times a year and we may also send you emails to gather your views.

I agree to register to join the Living Well Partnership Patient Participation Group.

☐ Yes ☐ No

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 hold on record for you.