**Drs K PRASAD, CA HUTSON & B CHANDRAN**

**Treeton Medical Centre**

 10 Arundel Street, Treeton, Rotherham,

South Yorkshire, S60 5PW.

Telephone 0114 2692600 Fax 0114 2693296

Carer Information

Treeton Medical Centre is forming a Carers Register to ensure that the needs of carers are considered. If you are a patient at this surgery, or care for a patient at this surgery it will be very relevant for us to have the following information. If you are a patient of another surgery you might wish to contact them to see if they have a similar register to access information/support.

**I am a carer** and I understand and give permission for Treeton Medical Centre to record this fact in my medical records.

Name……………………………………………….

Address……………………………………………..

……………………………………………………….

Telephone Number………………………………..

**If the person you care for is a patient at this surgery please complete the details below:**

Name…………………………………………………

Address……………………………………………….

Telephone Number………………………………….

Signed ………………………………………………..

Date…………………………………………………..

Any information you give us permission to record on your records is subject to the requirements of the Data Protection Act 1998. For further information a copy of the surgery’s policy on “Patient Access to medical notes” is posted in the waiting room. We will seek your permission in writing before releasing information to any other parties (eg if you are making an insurance claim, we may be contacted by a solicitor or insurance company).

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Please give this to the person whom you are caring for.

Dear ………………………………….

We have been informed by …………………………………. that they are providing

care for you, we are seeking your permission to put their details into your computerised medical records and permission for us to be able to contact them in an emergency.

Also we will need your consent for your carer to speak to the GP on your behalf and for the Doctor to be able to discuss your medical conditions/medications relevant to your care.

I ……………………………………. give my permission for my

carer………………………….. details to be entered into my records and for them to

be contacted in an emergency.

Signed…………………………………………..

Name…………………………………………….

Date……………………………………………….

I also give the Doctors my permission for my carer to receive information about my medical conditions/medications relevant to my care.

Signed………………………………………………..

Name………………………………………………….

Date…………………………………………………..

Contact Telephone No………………………………

We may contact you to verify the details completed on this form.

Any information you give us permission to record on your records is subject to the requirements of the Data Protection Act 1998. For further information a copy of the surgery’s policy on “Patient Access to medical notes” is posted in the waiting room. We will seek your permission in writing before releasing information to any other parties (eg if you are making an insurance claim, we may be contacted by a solicitor or insurance company).