**UNDER-16s PARENTS/GUARDIANS FORM & CONSENT FORM**

**Parents/Guardians of child wishing to be registered**

Full Name Date of Registered at

(capitals please) Birth The Good Practice?

1. …………………………………………………………….. ………………… YES/NO

2. …………………………………………………………….. ………………… YES/NO

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Dear Patient

So that we can provide you with the best possible care we need to formally obtain your permission or refusal for us to share the medical information held by The Good Practice with other organisations that may care for you. If you refuse to share this information then we will not be able to refer you on to other organisations/services such as hospitals, district nurses and services such as podiatry, to name just a few examples.

We also require your formal permission or refusal for us to be able to view data about you that has been recorded at other services that care for you.

Please could you therefore tick your answer to the following two questions so that we can register your preferences and return this sheet to The Good Practice.

1. Do you consent to the sharing of data recorded here at The Good Practice with any other organisations that may care for you? **YES or NO**
2. Do you consent to the viewing of data by The Good Practice of data that is recorded about you at other care services where you have agreed to make the data shareable? **YES or NO**

You can change your consent at any time. Please be assured that we will never share your information with third parties such as employers, the police, friends and even family without first obtaining your permission.

Thank you, The Good Practice

**Patient’s name:**

**Patient’s Date of Birth:**

**Signature on behalf of patient aged under 16:**

**Name & relationship to patient of person signing:**

**Date:**