Acton Town Medical Centre

GDPR Patient Consent Form

By completing this form you (the patient) consent to being contacted by Acton Town Medical Centre by the methods you choose below.

A copy will be securely stored by the practice to record your consent being given. If you wish to withdraw this consent at any point, please contact the practice in writing.

Method of communication	Consent to receive communication via:
SMS (text message)	Yes / No
Telephone	Yes / No
Email	Yes / No
Post	Yes / No
Record Sharing/Shared Data with other NHS organisations, so in an emergency a NHS hospital for example can view your stored records.	Yes / No

Your Full Name	
Date of Birth	
Full Address, including postcode	
Home Telephone / Mobile Number	
Email Address:	
Patient's Signature	

Once completed please return to the practice

Privacy Protection:
Our practice has a strict confidentiality policy. This information is not shared with any third party organisations. For more information please visit our website or ask a member of staff.

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date

For Office Use Only: (Patients preferences updated on clinical system Yes /No)