

# Consent Form

Consent form (Releasing health records under the General Data Protection Regulation and the Data Protection Act 2018)

## Part A – patient's details

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Full name:

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Address:

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Postcode:

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Date of birth:

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NHS number (if known):

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GP's name and address  
(and phone number if  
known):

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## Part B – declaration and signature

- ☒ I am the patient named above.
- ☐ The patient named above is a child (under the age of 16), and I have the legal/parental responsibility as his/her .....

### To health professionals

I understand that filling in and signing this form gives you permission to give copies of all health records including complete GP records, and any hospital records to *The Royal Embassy of Saudi Arabia - Cultural Bureau of 630 Chiswick High Road, Chiswick, London W4 5RY* copies of my health records, in line with the Data Protection Act 2018.

This consent is freely given and can be withdrawn at any time.

Name:

Signature/  
Initials:

Date: