**Summary Care Record Consent Form**

A Summary Care Record (SCR), will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Please choose **one** of the options below and return the completed form to your GP Practice:

**a) Yes – I would like a Summary Care Record.** You wish to share information about medication, allergies and adverse reactions only.

□ Express consent for medication, allergies and adverse reactions only.

1. **Or** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

□ Express consent for medication, allergies, adverse reactions and additional information.

1. **No – I would not like a Summary Care Record).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

□ Express dissent for Summary Care Record (opt out).

You are free to change your decision at any time by informing your GP practice.

Name of Patient: ………………………………………………..…...............................................................

Address: …………………………………………………………………………………………………………………………….

Postcode: ………………………………………… Date of Birth: ………..........................................

NHS Number (if known): …………………………..………………...........................................................

Signature: ………………………………………………………….. Date: ………………………………………………

If you are filling out this form on behalf of another person, please fill out their details above; you sign the form above and provide your details below:

Name: …………..........................................................................................................................

**Please circle one:** Parent Legal Guardian Lasting power of attorney for health & welfare

If you require any more information, please visit <http://digital.nhs.uk/scr/patients> or phone NHS Digital on 0300 303 5678 or speak to your GP practice.