DR P J FRITH
DR K S BUTT
DR A LUCASSEN
DR J ELANGOVAN
DR P B DE SILVA
DR K RAHMAN
DR J DAR

OAKWOOD SURGERY
CHURCH STREET
MANSFIELD WOODHOUSE
NOTTINGHAMSHIRE
NG19 8BL
PHONE: 01623 435555
FAX: 01623 423480

EDSM Consent Form

Name: _____ Date of Birth _____

Address: _____

Post Code: _____

Telephone: _____

I, have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet "Your electronic patient record & the sharing of information"

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share-out
I would* / would-not* like the information recorded at **Oakwood Surgery** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

Share-in
I would* / would-not* like the information recorded at other care teams who are involved in my care to be seen by members of the team at **Oakwood Surgery**, where I have granted those care teams the right to add to my shared data.

*** Delete as appropriate**

I understand that I can change my decision at any time.

Signed ……..

Patient …….. Date : _____

OR

Patient representative ……..

Relationship to patient ……..