**Patient Consent Form for Medical Record Access Restriction**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHS Number (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, [Patient Name], confirm that I would like to restrict access to my medical records from the following staff member(s):

Staff Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

* This restriction means that the named staff member(s) will not have access to my medical records.
* Restricting access may affect the efficiency of my care if the named staff member(s) are involved in administrative or clinical processes related to my treatment.
* Highfield Surgery operates as a team, and while my confidentiality will be respected, there may be instances where limited access is necessary for safe and effective healthcare.
* This restriction does not apply to other staff members involved in my care unless explicitly requested and agreed upon.
* I can revoke or amend this restriction at any time by submitting a written request to the practice.

By signing below, I acknowledge that I have read and understood the implications of this request, and I accept the potential risks associated with restricting access.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Office Use Only:

Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Processed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date restriction applied: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_