| Doctor/ Surgery Name: |
| --- |
| Surgery Address: |

# Consent to Disclose Confidential Medical Information

| **Name:** | **Date of Birth:** |
| --- | --- |
| **Address:** | |

I hereby consent to the disclosure of my full medical information including Consultations, Test results, Prescriptions, Appointments and Referrals, to:

The Clinic MK
18 Rockingham Drive
Linford Forum
Linford Wood East
Milton Keynes
MK14 6LY

**Sign:** ________________________________________ **Date:** ____/____/________