

# RIVERSIDE SURGERY

48 WORTHING ROAD · HORSHAM · WEST SUSSEX · RH12 1UD

Telephone: 01403 274700 · Fax: 01403 221999

I hereby give authorisation for details of my medical care and record to be shared with my carer.

Carer's name .....

Carer's address (inc postcode) .....

.....

Carer's date of birth.....

Carer's phone number.....

Their relationship to patient.....

Signed ..... Name (please print).....

Date of authorisation .....

## **TO AUTHORISE A 2<sup>ND</sup> CARER PLEASE FILL OUT THE SECTION BELOW**

Carer's name .....

Carer's address (inc postcode) .....

.....

Carer's date of birth.....

Carer's phone number.....

Their relationship to patient.....

Signed ..... Name (please print).....

Date of authorisation .....