**Dr P Craven & Dr S Garlapati**

**Allen Street Clinic**

**Allen Street**

**Cheadle, Staffordshire**

**ST10 1HJ**

**Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**I give permission for:**

**Full Name & Date of Birth …………………………………………………………………..**

**Relationship to patient…………………………………………………………………………**

**Email Address ……………………………………………………………………………………..**

**To have full access to my medical records and to discuss my medical issues on my behalf**

**To have access to the following on my behalf:**

**This is to apply until further instruction from myself.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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