***Physio to complete***

Ax date:

W/T:

D/Ch date:

DfI/BmPROM:

Ins Memb No:

Auth no:

No sessions:

**Privacy Consent Form**

***PLEASE PRINT ALL INFORMATION ON THIS FORM***

PATIENT NAME: ……………………………………………………. DOB: ……… /………/……….

ADDRESS: ………………………………………………………………………………………………….…

…………………………………………………………………………………………………………………

Post code: ……………………………………………………………………………………………………..

Daytime Telephone Number: ………………………………………………………………………………...

Mobile number (if different): ………………………………………………………………………………….

Email Address: ………………………………………………………………………………………………...

**Patient Consent:**

Rebecca Simpson Physiotherapy request your consent for the purpose of the General Data Protection Regulations 2018.

**Personal And Medical Data:**

I consent to the process of my personal and medical data using paper notes. Rebecca Simpson Physiotherapy require these details by law, and to help us in the management and treatment of your condition. They are also used to send letters to those referring you to the clinic on discharge, and for audit using anonymous data to ensure best practice. Rebecca Simpson Physiotherapy will not pass on your personal data to third parties without first obtaining your consent. For more information on how we manage your personal data please see our ‘Privacy Policy’.

*PLEASE TURN OVER*

**Privacy Policy:**

I have been made aware of the Rebecca Simpson Physiotherapy’s Privacy Policy which is available to read on the website and in the clinic. I have the right to receive a printed version of this policy, which will be given to me at my request.

Please tick appropriate box:

 ☐ Yes I have been made aware of the policy

☐ No I have not been made aware of the policy

**Your Rights:**

By consenting to this privacy notice you are giving us permission to process your personal data specifically for the purposes identified. Where we are asking you for sensitive personal data we will always tell you why and how the information will be used.

You also have the right to have your personal data deleted or amended on request and to withdraw treatment consent at anytime. However, we are required to retain medical notes pertaining to treatment episodes. Any withdrawal of treatment consent would result in termination of your treatment episode. Please see Privacy Policy for further details.

PATIENT NAME (Please Print):………………………………………………………………………………

PATIENT SIGNATURE:………………………………………………………………………………………

DATE:…………………………………………………………………………………………………………

If patient is under 16 or unable to understand the information contained:

PARENT/ GUARDIAN NAME:………………………………………………………………………………

PARENT/GUARDIAN SIGNATURE:………………………………………………………………………...

DATE:…………………………………………………………………………………………………………