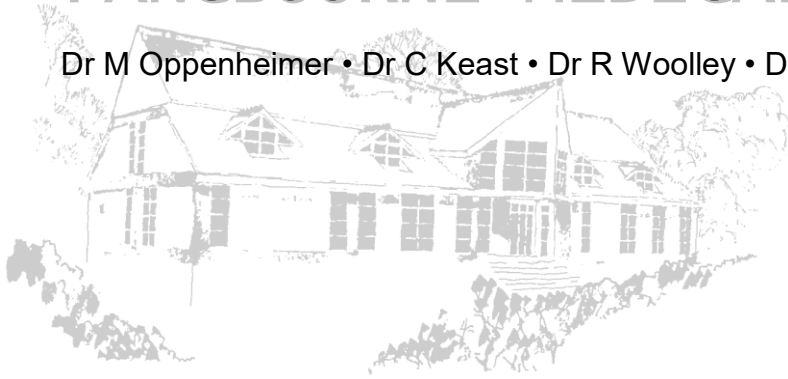


PANGBOURNE MEDICAL PRACTICE

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Date

PATIENT NAME

ADDRESS

D.O.B

I give consent to the person named below to have:

Full access to my medical records and conditions

Limited access to:
Please specify

NAME

ADDRESS

CONTACT NO

RELATIONSHIP TO PATIENT.....

Yours sincerely

PATIENT SIGNATURE

DATE