Local Data Sharing Opt In Form

I wish to request that other local healthcare providers are allowed to view my medical record under local data sharing arrangements.

Please note that this opt in form does not cover the local data sharing agreement called Connecting Care – if you would like to opt in to that, please ask for the Connecting Care opt in form.

I understand that I can change my mind about this at any time, and that to do so I should complete an opt out form.

Name: ……………………………………………………

DOB: ……………………………………………………..

NHS number (if known): …………………………………………….

Signature: ………………………………………………

Date: ………………………………….

Once complete, please return to Eastville Medical Practice reception.