The Friarsgate Practice
care.data Opt Out Form

Patient Details

Print Full Name:_____

Date of Birth:_____

Address:_____

I confirm that I do not want my confidential information being shared or used for any purpose other than providing me with care, except in exceptional circumstances.

Date:_____

Patient signature:_____

If the above patient is under 16

Relationship to patient:_____

Full Printed Name:_____

Signature:_____

Please return your completed form to the Friarsgate Practice.

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For Practice Use Only

Opt out code added to patient's medical record:

Date:

Signature: