

Thursby Surgery
Care Data
Withholding of Consent Form

Request for my Clinical Information to be withheld from the Care Data Extraction Service

I have read and understood the leaflet 'How information about you helps us to provide better care' and read the 'Frequently asked questions for patients' which is available in the surgery and also on the website and I do not wish my data to be shared.

Please complete in BLOCK CAPITALS

Title Surname / Family name

Forename(s)

Address

Postcode Phone No Date of birth

NHS Number (if known) Signature

If you are filling out this form on behalf of another person or a child, please ensure you fill out their details above and your details in this section.

Your name Your signature

Relationship to patient Date

Please indicate by ticking the boxes below at what level you are withholding consent (for detailed information regarding your choices and the implications of withholding consent see question 15-24 in the FAQ leaflet) :-

- I do not consent to my data leaving my GP Practice

- I do not consent to my data leaving the HSCIC secure environment.