Permission form

Your medical data available through the LSP

volg je zorg

I do / do not authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Yes! I want to share my medical records; Give permission to share your medical records!' leaflet.

GP or pharmacy details

Which healthcare provider does the form concern? (Healthcare provider 1)	☐ **my GP** ☐ **my pharmacy**	☐ **YES** ☐ **NO**

Name: .....

Address: .....

Postcode and town: .....

Which healthcare provider does the form concern? (Healthcare provider 2)	☐ **my GP** ☐ **my pharmacy**	☐ **YES** ☐ **NO**

Name: .....

Address: .....

Postcode and town: .....

My details Do not forget to sign the form.

Family name: ..... **Initials:** ..... ☐ **M** ☐ **F**

Address: .....

Postcode and town: .....

Date of birth: ..... **Signature:** .....

Date: .....

Do you wish to arrange permission for your children?

- For children up to age 12: the parent or guardian gives permission. Please use this form.
- For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign this form.
- Children aged 16 and over need to give permission themselves and fill-out their own form.

Details of my children

Complete the below details of the children with respect to whom you wish to give permission. Do not forget your own signature.

Family name: ..... **Initials:** ..... ☐ **M** ☐ **F**

Date of birth: ..... **Signature:** ..... ☐ **YES** ☐ **NO**

Family name: ..... **Initials:** ..... ☐ **M** ☐ **F**

Date of birth: ..... **Signature:** ..... ☐ **YES** ☐ **NO**

Do you have more than two children? Please complete a new permission form.

Signature parent or legal guardian:: ..... **Date:** .....

Submit this form to the GP of pharmacy your permission concerns.

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