DATA SHARING OPT OUT FORM (PLEASE TICK AS RELEVANT)

COMMON HEALTH & INFORMATION EXCHANGE (CHIE)

[ ] * **I would** like to have a Hampshire Health Record (now called CHIE)
[ ] * **I WOULD NOT** like to have a Hampshire Health Record (now called CHIE)

SUMMARY CARE RECORD

[ ] * **I DO** want to have a Summary care record
[ ] * **I DO NOT** want to have a Summary Care record

What does it mean if I DO NOT have a Summary Care Record?

NHS CARE STAFF CARING FOR YOU MAY NOT BE AWARE OF YOUR CURRENT MEDICATIONS, ALLERGIES YOU SUFFER FROM AND ANY BAD REACTIONS TO MEDICINES THAT YOU HAVE HAD, IN ORDER TO TREAT YOU SAFELY IN AN EMERGENCY.
YOUR RECORDS WILL STAY AS THEY ARE NOW WITH INFORMATION BEING SHARED BY LETTER, EMAIL, FAX OR PHONE.
IF YOU HAVE ANY QUESTIONS, O IF YOU WANT TO DISCUSS YOUR CHOICES, PLEASE PHONE THE SUMMARY CARE RECORD INFORMATION LINE ON 0300-123-3020.

CARE DATA

[ ] * **I DO** want my personal confidential data to be released by my GP surgery for the care date programme.
[ ] * **I DO NOT** want my personal confidential data to be released by my GP surgery for the Care Data Programme.

[ ] * **I DO** want my personal confidential data from hospitals and other care providers to be released by the Health & Social Care Information Centre (HSCIC) for the data care programme.
[ ] * **I DO NOT** want my personal confidential data from hospitals and other care providers to be released by the Health & Social Care Information Centre (HSCIC) for the care data programme.

OTHER NHS PROVIDERS (SUCH AS DISTRICT NURSES, OVER 75'S NURSES, PODIATRY, LEG ULCER CLINICS, DIABETES SERVICES ETC…..)

[ ] * **I DO** wish for any part of my medical record to be shared with other services within the NHS
[ ] * **I DO NOT** wish for any part of my medical records to be shared with other services within the NHS

**** I confirm that if I have not ticked a particular box then I am consenting to share data with other healthcare providers****

SECTION A – IT IS IMPORTANT THAT YOU COMPLETE THIS SECTION ACCURATELY AND PLEASE USE BLOCK CAPITALS

TITLE	
FORENAME[S]	
SURNAME	
ADDRESS	
MOBILE PHONE NO	*I DO NOT consent to receive text messages [ ]
EMAIL ADDRESS	*I DO NOT consent to receive emails [ ]
DATE OF BIRTH	
NHS NUMBER [IF KNOWN]	
PATIENTS SIGNATURE	
DATE	

If you are filling this form on behalf of another person or child, their GP practice will check that you have the authority to do so. Please ensure that you fill out their details in section A and your details are in Section B

SECTION B

Your Name	
Relationship to Patient	
Your signature	
Date	

PLEASE HAND THIS FORM TO INTO YOUR GP PRACTICE (OR IF SIGNING ON BEHALF OF SOMEONE ELSE THEIR GP PRACTICE