Hounsfield Surgery
Care Data
Withholding of Consent Form

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

If you do not want your data to be shared please fill out the form and send it to the Practice as soon as possible.

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 http://www.england.nhs.uk/wp-content/uploads/2014/01/cd-patient-faqs.pdf):-

☐ XaZ89 - I do not consent to my data leaving my GP Practice

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