



CONSENT FORM

Enquiry to the Trust by Elected Representatives

Full name of service user: _____ (print name)

Address: _____

Telephone number: _____

Date of birth: _____

Hospital/Facility/Service: _____

I hereby authorise: _____ (print name of elected representative)
to act on my behalf and to receive any and all such information as may be relevant to the enquiry.
This will involve disclosing confidential or personal information on me, my care and my
circumstances.

Signed: _____ (by service user)

Date: _____

Where the service user does not have capacity to consent, I am the appropriate person to act as their representative.

Appropriate person's name: _____ (print name)

Appropriate person's signature: _____

Relationship to service user: _____

Reason why the service user does not have capacity to consent themselves. Please enclose supporting evidence (where applicable): _____

Date: _____