# Information Sharing Opt-Out Form

*Please return to The Arnewood Practice*

**Request for my clinical information to be withheld from sharing between GPs, community and mental health staff.**

*Only complete this form if you* **DO NOT** *want your clinical records shared with other services involved in your care, please complete this form and return it to the practice.*

**Title**…….. **Surname**……..

**Forename(s)**……..**Date of Birth** ……../……../……

**Address**

**Postcode**……

**Telephone Number**…….

**NHS Number (if known)** ……..

**Signature**……..

If you are filling this form out on behalf of another person or child, please also complete the following:

**Your Name**……..

**Your Signature**……..

**Relationship to patient**……..**Date**……