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**CONFIDENTIAL**

**OPT-OUT FORM**

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**Request for my information not to be available to view in Connect Care**

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**What does it mean NOT to have a Connect Care Record?**

The staff caring for you may not be aware of your current medications and allergies, or other important

information about your health and care. Your information will continue to be shared by letter, email, fax or

phone. You can change your mind at any time and opt back in.

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If you **DO NOT** want your information to be viewed in Connect Care please fill out the form and return it to

“FREEPOST LGT” (please make sure that you write this in capitals). **Forms sent anywhere else will not**

**beactioned.**

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If you have any questions, or if you want to discuss your choices before completing this form, please call

020 8314 0481 and leave your name and number for someone to contact you, or visit the website

[**www.lewishamandgreenwich.nhs.uk/connectcare**](http://www.lewishamandgreenwich.nhs.uk/connectcare)

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**Please complete the PATIENT DETAILS in BLOCK CAPITALS**

Title: ........................................... Surname / Family name: ..............................................................................................

Forename(s): .....................................................................................................................................................................

Address: .............................................................................................................................................................................

Postcode: ......................................................................... Phone No: .............................................................................

Date of birth: .................................................................... NHS Number (if known): ........................................................

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I am the person named above.

The person named above is under 16 and I am their legal guardian / have parental responsibility.

The person named above does not have capacity to give consent and I have lasting power of attorney. I request that my / their information is not available to view in Connect Care and that no Connect Care record be available to assist in treating me / them, even in an emergency situation.

I confirm that I have read the “Deciding not to have a Connect Care record” information sheet and that I

understand the consequences of taking this action and have carefully considered the implications of this for

my / their health and care.

Signature: ............................................................................................. Date: ................................................................

Relationship to person/child: ………………………………………………..Phone No: ......................................................

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OFFICE USE ONLY: Request Actioned On: Reference Number: