

Group Consultations Confidentiality Form

Name			
Home Address:			
Date of Birth:		Phone number:	

Introduction to this Confidentiality Agreement

As a participant in Group Consultations, you and the other patients sharing the appointment will discuss medical information in the presence of additional patients and staff. This applies equally whether attending a group consultation in person or virtually, using a secure video and/or audio link to both the main session and any microconsults. Your clinician (doctor, nurse, or pharmacist) and other members of your healthcare team, including students if present, will also be doing the same. Staff and students are bound by their employment or educational contracts and professional codes of ethics to respect patient confidentiality. Please read the statement below, and if you agree, sign the form where indicated.

Statement of Confidentiality

By signing this agreement, I commit to maintaining the confidentiality of the other members of the Group Consultation by refraining from disclosing any medical, personal, or other identifying information about others present, once the session concludes. If I am participating virtually, I will ensure that others cannot hear or see the group consultation unless they are my carer, who has also signed this form, and that it will not be recorded by anyone. My own information, however, is my own, and I understand that I am encouraged to share my own details with my carer or other family members, as applicable.

I understand that if I have sensitive health concerns, I may, of course, ask to discuss them with the relevant staff member in a private treatment room, opt for a 1:1 discussion at the end of the session in person or virtually, or schedule an individual appointment.

I understand that I am under no obligation to share personal information with other patients or healthcare staff unless I choose to do so. However, by signing this confidentiality form, I agree to share any relevant test results within my group.

At any time, I can withdraw my consent to this.

Signed (patient):

Date:

Signed (carer/support person/student if applicable):

Date:

I consent as above in **all** of my group consultation sessions at St John the Evangelist Church.

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Medical Group

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Medical Centre

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