Client Record Card: - These details will remain private and confidential

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P.CODE

MOBILE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: (M/F)

Doctor’s Details

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SURGERY

Client Declaration

I am aware that this treatment is not a substitute for medical advice or treatment I agree that to the best of my knowledge the details contained in this document are correct. I have completed the Covid 19 risk assessment and agree to comply with health and safety measures required by practitioner.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GDPR: General Data Protection Regulation Policy. May 2018.**

This is to advise that you grant permission for me to retain, in locked files, details of your address, age, medical details and details of treatment for a period of eight years.

The information is necessary to enable me to formulate adequate treatment for you and will not be passed on to any third party.

At the end of the eight -year period the record will be destroyed.

**I understand and grant permission for the above actions.**

Name (Printed):

Signature