



**Scotstown
Medical
Group**

CAIRNFOLD ROAD
BRIDGE OF DON
ABERDEEN
AB22 8LD
Telephone 0345 189 7070

Dear Sir/Madam

Please complete this form to nominate a representative to receive TEST RESULTS and MESSAGES on your behalf.

Details of Patient

Name:- _____

Date of Birth:- _____

Address:- _____

I (name as above) give consent for the below Representative to receive any test result or messages on my behalf.

Please complete the following in capital letters.

Name of Representative :- _____

Relationship to Patient :- _____

Signature of Patient:- _____

Date signed :- _____

Partners Dr A A Forbes Dr R Gupta Dr B Crockett
Dr J Stewart Dr R Kilfeather
Assistant – Dr S Al-Hassani