

**Form A: consent to share my information with others**

I,		
	<i>Insert your full name</i>	<i>Insert your date of birth</i>
of		
	<i>Insert your full name</i>	
give my consent for The ADHD and Autism Clinic to share information about my care with:		
<i>Insert name and address of third-party (e.g. your family member, your private medical insurer, your employer/university etc)</i>		
Any information which I do not wish The ADHD and Autism Clinic to share is listed/detailed below.		
<i>Please list/detail the information which you do not wish The ADHD and Autism Clinic to share. Or, write "not applicable" or "n/a"</i>		
Signed		
Dated		

**Important notes**

For information about how The ADHD and Autism Clinic use your data, please visit [www.adhdandautismclinic.co.uk/privacy-policy](http://www.adhdandautismclinic.co.uk/privacy-policy)