_ _
(NAME)

Permission to treat / Data Protection Declaration

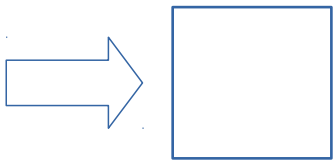
Please initial /delete the following as appropriate, and sign below.

Signature required due to changes in EU/UK law affective from 25th May 2018

initials

TREATMENT

I give permission to treat my baby/child (this must be initialled for any children under 16yo). I note that a responsible adult should also be in the room during treatment.



DATA PROTECTION

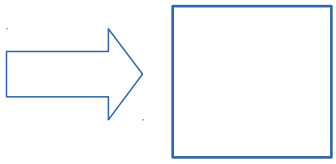
Confidential patient notes will only be kept as a single copy in paper form. (By Law these must be retained for at least 7 years following any treatment.)

Personal data will not be passed on to third parties except on your direct instruction (e.g. insurance claims).

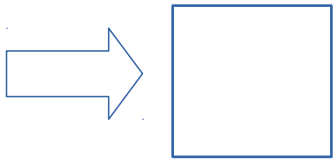
Contact details ONLY may also be kept in *electronic* form.

Any permissions may easily be revoked by sending a reply to any circular you receive with the word "REMOVE" on the subject or top contents line.

I agree that you may use my contact details as necessary regarding *current* treatment/appointments.



I agree to receive occasional (no more than 2/year) email/SMS information about available workshops or clinic details.



_ _
(NAME)

_ _
(Signature)

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(Date)