



CONSENT TO DISCLOSURE OF PERSONAL INFORMATION

The Data Protection Act 2018 imposes strict rules on releasing your details to anyone. In order to assist you, your health care representative will need to provide some of your details to Perth and Kinross Council.

I (NAME) _____ Date of Birth: _____

Address: _____

CONSENT TO (HOSPITAL NAME) _____

PROVIDING PERTH & KINROSS COUNCIL WITH PERSONAL INFORMATION AS REQUESTED BELOW: Please tick

Signature: _____ Date: _____

Hospital Details

Name of Hospital _____

Date of Admission: _____

Date of Transfer to Care Home (if applicable): _____

Name and Address of Care Home: _____

DECLARATION

Please note that this declaration should only be completed by a medical practitioner or an authorised official who can verify that the Applicant is or has been admitted to the hospital and not able to return to their home.

I declare that the above particulars are true and accurate and that the Applicant has been admitted to the hospital and is unable to return home.

Print Name Hospital Official: _____

Signature: _____ Position: _____

Date: _____

Once completed this form should be returned to Local Taxes, Perth and Kinross Council, PO Box 7300, Perth, PH1 5WH. Alternatively it can be emailed to local-taxes@pkc.gov.uk