ACMEDICALSERVICES

Withdrawal Patient Consent Form

First Name:		**Patient Date of Birth:**	
Last Name:		**Contact Number:**	
Address:		**Ethnicity:**	
GP Name/ Address:		**Gender:**	

This is confirmation of my withdrawal to consent for AC Medical Services Ltd. to conduct a medical report on my behalf or to conduct a procedure.
Everyone aged 16 or more is presumed to be competent to withdraw consent for themselves, unless the opposite is demonstrated.
If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then s/he will be competent to withdraw consent for him/herself.
Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this Withdrawal Form for themselves but may wish a parent to countersign as well.
If the child is not able to withdraw consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this form below.
If the patient is classed as being clinically vulnerable or is mentally unable to withdraw consent, this form may be signed for on their behalf by a patient or by a carer.

Signed:	
Parent/ Guardian signature if patient is under 16 years of age or classed as vulnerable:	
Relationship to patient if Signed Above:	
Date:	Click or tap to enter a date.