Whitstable Medical Practice
Patient Participation Group

Confidentiality Code of Conduct

During your time volunteering for the Whitstable Medical Practice Patient Participation Group (WMP PPG), you may acquire or have access to confidential information which must not be disclosed to any other person unless in pursuit of your duties or with specific permission given by a person on behalf of the WMP PPG. This condition applies during your relationship with the group and after the relationship ceases.

Confidential information includes all information relating to Whitstable Medical Practice, its patients and staff. Whilst participating with the WMP PPG, you may come into contact with this information.

An example of the WMP PPG commitment to the General Data Protection Requirements legislation is the request for your authorisation to access your contact information so that the group can invite you to meetings and/or send you information about its services.

Please complete the Declaration overleaf.

Please return this form to:

Patient Participation Group,
Estuary View Medical Centre, Boorman Way, Whitstable, CT5 3SE

Or e-mail to: supreet.kaur@nhs.net

Name: ……

Address: ……
……
……
Post Code ……

Email: ……
Home Tel: ……
Mob Tel: ……

Please state how you prefer to be contacted:……..

DECLARATION OF INTEREST
Please list your interests in any aspect of health and social care:
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……
……
……
……

PLEASE READ AND SIGN BELOW
I understand the above, and that I am bound by a duty of confidentiality and agree to adhere to this code of conduct and the requirements of the General Data Protection Regulations (May 2018).

PLEASE TICK THE BOX WHICH APPLIES TO YOU:

☐ I am happy for my contact details to be shared by WMP-PPG in order to invite / contact me directly. This will include the communication of emails between other PPG members as well as minutes of meetings and other information from practice staff.

☐ I am NOT happy for my contact details to be shared with WMP-PPG in order to invite / contact me directly.

Signature: …… Date:……

Print Name: ……

ON BEHALF OF WMP-PPG

Signature: …… Date:……

Print Name: ……

Position held:……

A COPY OF THIS DECLARATION WILL BE RETAINED BY WHITSTABLE MEDICAL PRACTICE