FORM OF AUTHORITY FOR RELEASE OF ALL MEDICAL RECORDS

(Please correct any pre-entered details and enter as much information as possible in the boxes)

FULL NAME & ADDRESS OF INJURED PERSON :

DOB DATE OF INJURY

TEL (DAY) (EVG)

GP (GENERAL PRACTITIONER) DETAILS

NAME & ADDRESS OF GP (GENERAL PRACTITIONER)

HOSPITALS ATTENDED AFTER THIS INJURY

NAME & ADDRESS OF HOSPITAL

HOSPITAL NUMBER

DID YOU ATTEND THE A&E DEPT ?
ALL OTHER DEPARTMENTS ATTENDED (with approx dates)

CONSULTANT (in charge of your care)

DID YOU HAVE X-RAYS / SCANS ?
(please give details of part of body x-rayed / scanned)

NAME & ADDRESS OF HOSPITAL

HOSPITAL NUMBER

DID YOU ATTEND THE A&E DEPT ?
ALL OTHER DEPARTMENTS ATTENDED (with approx dates)

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(please give details of part of body x-rayed / scanned)

AUTHORISATION : "TO WHOM IT MAY CONCERN"

I hereby give you my permission and request you to release full details and copies of all hospital, general practitioner records, X-rays and scans, occupational health records, Department of Social Security records or reports from medical appeal tribunals, nursing and any psychiatric notes that may exist and any other medical records as may be required to DOCTORS CHAMBERS of Crown House, William St, Windsor, SL4 1AT and any expert appointed by them. I also authorise the report and medical records to be sent to Doctor's Chambers and their instructing Solicitors / Insurance Company and / or rehabilitation service provider .

I confirm that this information is not required in respect of a claim for medical negligence against the above doctor, health authority or its servants and agents.

I AM THE PATIENT / PARENT OF THE ABOVE / LEGAL GUARDIAN OF THE ABOVE (please select)

I have reviewed and understood the authorisation above

Signed Full name Dated

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