FORM OF AUTHORITY FOR RELEASE OF ALL MEDICAL RECORDS AND REPORTS

Please enter as much information as possible in the sections below

1. INJURED PERSON'S DETAILS

Doctors Chambers (UK) Reference:		Date of Injury:	
Full Name:			
Address:			
Date of Birth:			
Mobile No:			
Email Address:			

2. GENERAL PRACTITIONER (GP) DETAILS – details of current registered practice

GP Name:	
GP Address:	
GP Tel Number:	

3. WHICH OF THE FOLLOWING SERVICES YOU ATTENDED:

If you have not attended any of the above, please skip to Section 4.

Service Attended	Date Attended	Name of Organisation, Department Attended and Details of part of body x-rayed/scanned if X-rays/scans were taken.	Address of Organisation
Hospital: (1)			
Hospital: (2)			
Treatment Centre:			
Other: Ambulance/ Dentist			

4. 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 for Work and Pensions 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 (UK) Limited of Crown House, William Street, Windsor, SL4 1AT and any expert/s appointed by them, the Instructing Solicitor/Insurance Company and/or rehabilitation and other service providers as required in connection with my claim. I understand this form will be shared with the health organisations mentioned above.

Please confirm who you are in relation to the person named above:

I am **THE PERSON NAMED ABOVE / PARENT / LEGAL GUARDIAN**

I have reviewed and understood the authorisation above:

Full Name:

Signature:

Date: