

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

Bodycare Clinics Ref.	
Full Name	
Address	
Date of Birth	
Date of Injury	
Mobile No	
Email Address	

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

GP Name	
GP Address	
GP Tel Number	

3. WHICH OF THE FOLLOWING SERVICES DID YOU ATTEND

If you have not attended any please skip to Section 4.

Service Attended	Date Attended	Name of Organisation and Department Attended	Address of Organisation
Ambulance Service:			
Hospital:			
Dentist:			
Treatment Centre:			
Other Health Org: E.G. XRAYS / SCANS			

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 Bodycare Clinics Limited of Unit 5, Silver Fox Way, Cobalt Business Park, Newcastle upon Tyne, NE27 0QJ and/or 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: