FORM OF AUTHORITY FOR RELEASE OF ALL MEDICAL RECORDS AND REPORTS Please enter as much information as possible in the sections below		
Doctors Chambers (UK) Ref:		
1) Full Name & Address of Injured Person:	Date of Birth:	Date of Injury:
	Home Tel No:	
	Work Tel No:	
	Mobile No:	
	Email Address:	
2) GP (GENERAL PRACTITIONERS) Full Name and address:	3) Did you attend any of the following, if so, please tick and provide full details in Section 4:	
	Hospital	☐
	Dentist	☐
	Treatment Centre (i.e. physio, chiropractor, osteopath etc)	☐
GP Telephone Number:	Any other health organisations	☐
	If you have not attended any of the above, please skip to Section 5	☐

4) Name and address of Hospital, Dentist, Treatment Centre or any other Health Organisations you may have attended	Departments attended and names of treating consultants. (If X-rays/scans were taken, please provide details of part of body x-rayed/scanned)	Dates attended

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 Street, Windsor, SL4 1AT and any expert/s appointed by them.

I also authorise the release of medical records and any medical reports to Doctors Chambers and their 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.

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

5) I AM THE **PATIENT/PARENT OF THE ABOVE/LEGAL GUARDIAN** OF THE ABOVE (please select)
I have reviewed and understood the authorisation above

SIGNATURE	FULL NAME	DATE