

AUTHORITY FOR RELEASE OF MEDICAL NOTES AND RECORDS

I { MERGEFIELD LINKNAME_FORENAME_1 } { MERGEFIELD LINKNAME_SURNAME_1 } of { MERGEFIELD "LINKNAME_FORENAME_1" } { MERGEFIELD "LINKNAME_SURNAME_1" } of { MERGEFIELD "CLIENT_HOUSE" }, { IF { MERGEFIELD CLIENT_AREA }= "" "" "{ MERGEFIELD CLIENT_AREA }, " } { MERGEFIELD "CLIENT_POSTAL_TOWN" }, { IF { MERGEFIELD CLIENT_COUNTY }= "" "" "{ MERGEFIELD CLIENT_COUNTY }, " } { MERGEFIELD "CLIENT_POSTCODE" } hereby authorise the release of my medical records, notes, reports and x-rays to { ASK who "Enter name of person requiring access to client's medical records." \d " " } { REF who * MERGEFORMAT } for the purpose of preparing a medical report arising out of the accident on { MERGEFIELD TK_ACCDETS_tkACCDATE }.

The name and address of my General Practitioner is: { MERGEFIELD TK_PIINJMEDDETS_tkGPNAME } of { MERGEFIELD TK_PIINJMEDDETS_tkGPSURGERY }

The Hospital I have visited is: { MERGEFIELD TK_PIINJMEDDETS_tkHOSPITAL_name } { MERGEFIELD TK_PIINJMEDDETS_tkHOSPITAL_address }

My date of birth is: { MERGEFIELD TK_PICLIENTINFO_tkCL_DOB }

My National Insurance No. is: { MERGEFIELD TK_PICLIENTINFO_tkNINUMBER }

I certify that no legal action is contemplated against my General Practitioner and/or the Health Authority in respect of any medical treatment received.

Signed

Dated

Relationship

(NB: If the injured party is under 18 years old, consent must be given by parent or guardian.)

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