

AUTHORITY FOR DISCLOSURE OF INFORMATION REQUIRED FOR MEDICAL REPORTS

Please return this completed form to Martin & Nierada, Solicitors, Bank Place, 33 High Street, Pwllheli, Gwynedd, LL53 5SF as soon as possible quoting reference MN/

NAME IN FULL: (including your former name if changed since date of accident)

DATE OF BIRTH:

DATE OF ACCIDENT:

NATIONAL INSURANCE NUMBER:

ADDRESS AND POSTCODE (including former address if changed since accident)

CONTACT TELEPHONE No: HOME WORK

HOSPITAL ATTENDED IMMEDIATELY AFTER ACCIDENT (If known please give hospital or record number and name of Consultant or Doctor attending). Please give full address if known.

HOSPITALS SUBSEQUENTLY ATTENDED (Please provide full name(s) and address(es).

GENERAL PRACTITIONER'S NAME AND ADDRESS

CONSENT FOR GENERAL PRACTITIONER'S RECORDS

I consent to the disclosure of all my General Practitioner's records to Martin & Nierada, Solicitors and/or the production of a medical report. I confirm that no action is contemplated by me against my General Practitioner or any member of his/her staff. In relation to any records after 1 November 1991, this consent can be taken as my authority under Section 3 (l) (b) of the Access to Health Records Act 1990.

Signed.....Dated.....

CONSENT FOR HOSPITAL RECORDS

I consent to the disclosure of all my Hospital Records and X-rays to Martin & Nierada, Solicitors and/or the production of a medical report. I confirm that no action is contemplated by me against the hospital, or any member of its staff. In relation to any records after 1 November 1991, this consent can be taken as my authority under Section 3 (l) (b) of the Access to Health Records Act 1990.

Signed.....Dated.....