|  |  |
| --- | --- |
| **Your full name:** |  |
| **Your address:** |  |
| **Date of birth:** |  |
| **Contact Telephone Number:\*** |  |
| **Email address:\*** |  |
| **Solicitor’s or agent’s name and address (if applicable):** |  |
| **GP’s name and address:** |  |

**\* By providing us with your email address and/or mobile number you consent to be contacted by email and/or SMS**

**Part A)**

If you only require information from a **specific part of your medical history**, please specify this below.

|  |
| --- |
| **Information/details as follows:** (Please outline the information you authorise to release) |

I can confirm that I give permission for the above information to be released only.

|  |  |
| --- | --- |
| **Your Signature:** |  |
| **Date:** |  |

**Part B) only sign below if you require a copy of your entire record.**

I understand that filling in and signing this form gives you permission to give copies of all of my GP records**.**

|  |  |
| --- | --- |
| **Your Signature:** |  |
| **Date:** |  |