FORM OF AUTHORITY

REQUEST FOR DISCLOSURE OF HOSPITAL MEDICAL RECORDS

Name:

Address:

Date of Birth:

Hospital(s) Attended:

1.

2.

3.

I …… Of ……..

(date of birth ……) hereby consent to the disclosure of all my medical records, correspondence and imaging to NHS Resolution, its legal advisers and any experts nominated by them, under the General Data Protection Regulations.

.....
SIGNED BY

.....
DATED