



## AUTHORISATION FOR RELEASE OF HEALTH RECORDS

Please complete in **BLACK INK, SIGN** and **RETURN** to UK Independent Medical, Indigo House, Belmont Business Park, DH1 1TW.

I,  of

authorise the release of all of my health records, hospital records, GP records, X-rays and scans and medico-legal reports, to **UK Independent Medical of Indigo House, Belmont Business Park, Durham** or their nominated medical expert(s), in accordance with the **Data Protection Act 1998**.

My date of birth is

UK Independent Medical will be responsible for all fees involved for the release and provision of the health records, hospital records, GP records, X-rays or scans, and medico-legal reports, limited to the prescribed **maximum fee of £50.00** inclusive of postage and copying charges in accordance with the **Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Act 1998**.

I understand that filling in and signing this form gives permission for all my health records to be given to UK Independent Medical who will give them to my nominated medical expert and my solicitor as required for the purposes of the litigation that I am involved in. If requested to do so by my solicitor, UK Independent Medical will retain an archived copy of my records for the purposes of providing timely responses to queries from my solicitor or my nominated medical expert. These records will be retained for a maximum period of 18 months from the date of the completed medical report (or earlier if specifically requested to do so), after which they will be securely destroyed.

I also understand that under court rules the other party may see all my health records.

Proceedings **ARE NOT** contemplated against my GP, Hospital or other health care provider, their servants or agents.

A copy of this consent shall have the validity of the original and therefore may be used to obtain my notes and records.

Please give UK Independent Medical copies of my health records, in accordance with the Data Protection Act 1998, within 40 days.

**Dated** \_\_\_\_\_

**Signed** \_\_\_\_\_

### NB HAVE YOU FILLED IN YOUR GP & HOSPITAL DETAILS?

Print Your Name:

UKIM Reference:

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**PLEASE ENTER BELOW THE NAMES AND ADDRESSES OF ANY MEDICAL FACILITIES YOU ATTENDED IN CONNECTION WITH YOUR ACCIDENT ONLY**

IMPORTANT – PROVIDE THE **POSTCODE** AND **TELEPHONE** NUMBER WHERE INDICATED

Your name and address:

UK IM Ref:

Accident Date:

/ /

Please confirm below that your personal details are complete and correct:

Your FULL Name:.....

Date of Birth:..... Contact Telephone No: ..... Years resident in the UK.....

**HOSPITAL 1**

**HOSPITAL 2**

**PHYSIOTHERAPIST/OTHER**

Name..... Name ..... Name .....

Address ..... Address ..... Address .....

Post Code ..... Post Code ..... Post Code .....

Telephone No ..... Telephone No ..... Telephone No.....

DID YOU ATTEND A&E? YES / NO DID YOU ATTEND A&E? YES / NO WERE XRAYS TAKEN? YES / NO

WERE XRAYS TAKEN? YES / NO WERE XRAYS TAKEN? YES / NO WERE MRI'S TAKEN? YES / NO

If YES what Date Approx ..... If YES What Date Approx.....

WERE MRI'S TAKEN? YES / NO WERE MRI'S TAKEN? YES / NO

**YOUR GP**

(EVEN IF YOU DIDN'T ATTEND FOLLOWING THE ACCIDENT)

GP's Name .....

Address .....

Post Code ..... Telephone No. ....

WERE XRAYS TAKEN AT THE GP's REQUEST? YES / NO

WERE MRI'S TAKEN AT THE GP's REQUEST? YES / NO