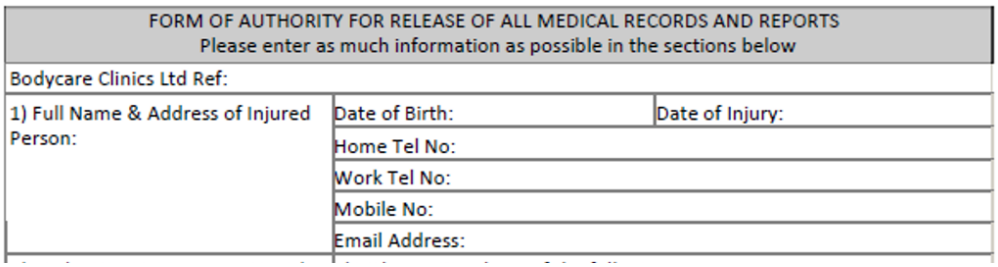
A GUIDE TO COMPLETING YOUR FORM OF AUTHRORITY FROM BODYCARE CLINICS LTD

Section 1 - Your Personal Details

Please ensure that you fill in all your personal details on the form. This helps to ensure that the information we have on our system is up to date and correct.

Add you name and address on the left-hand side then enter your date of birth, injury date, phone numbers and email address on the right-hand side.

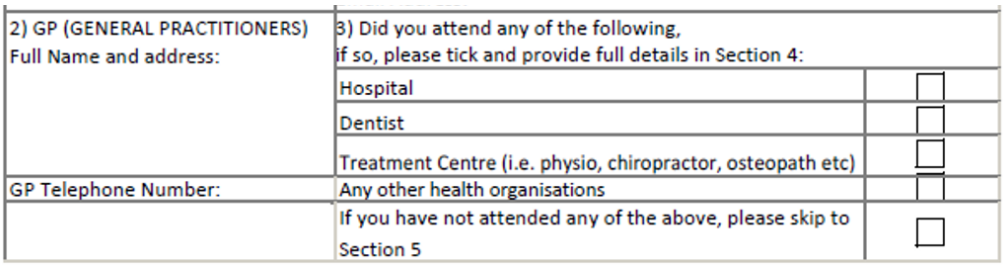
The more contact information you can provide us with will ensure we can contact you quickly should the need arise.



FORM OF AUTHORITY FOR RELEASE OF ALL MEDICAL RECORDS AND REPORTS Please enter as much information as possible in the sections below		
Bodycare Clinics Ltd Ref:		
1) Full Name & Address of Injured Person:	Date of Birth:	Date of Injury:
	Home Tel No:	
	Work Tel No:	
	Mobile No:	
	Email Address:	

Section 2 & 3 - Your GP Surgery Details/Other Treatment

If your solicitor or Insurance Company have requested that the chosen expert has sight of your medical records then your GP records will be required. Please complete the address box with the details of your surgery and their telephone number. If you are aware that there is more than one surgery in the building, then please provide the name of your surgery or your doctor. This will ensure our request gets to the correct organisation. We will also need details of any other medical treatment in relation to your claim. This includes visits to A&E, X-Ray departments and any treatment you may have had such as Physiotherapy or Chiropractic treatment. Please tick the corresponding box before moving on to Section 4 to provide full details of these visits.



2) GP (GENERAL PRACTITIONERS) Full Name and address:	3) Did you attend any of the following, if so, please tick and provide full details in Section 4:	
	Hospital	☐
	Dentist	☐
	Treatment Centre (i.e. physio, chiropractor, osteopath etc)	☐
GP Telephone Number:	Any other health organisations	☐
	If you have not attended any of the above, please skip to Section 5	☐

Section 4 - Other Treatment Details

If you have filled in section 3 advising that you have had other medical treatment, this will need added to section 4 with details of your treatment. If you have attended hospital after your accident, then we will require this information. You will need to provide the name of the hospital you attended, the departments visited (e.g. A&E and X-Ray) and the dates attended (if you know them). Similarly, if you have attended a clinic (e.g. for Physiotherapy) we will require the full name and address of the Company who treated you. If possible, please supply dates of attending that clinic even if you only have a rough idea (e.g. March 2025 – June 2025)

4) Name and address of Hospital, Dentist, Treatment Centre or any other Health Organisations you may have attended	Departments attended and names of treating consultants. (If X-rays/scans were taken, please provide details of part of body x-rayed/scanned)	Dates attended

Section 5 - Authorisation

Please sign and date the form, if the client is under 16, a parent or legal guardian will need to sign on their behalf. Return the form to us by email, where possible or by post.

Email address; medicals@bodycareclinics.com

I hereby give you my permission and request you to release full details and copies of all hospital, general practitioner records, X-rays and scans, occupational health records, Department of Social Security records or reports from medical appeal tribunals, nursing and any psychiatric notes that may exist and any other medical records as may be required to Bodycare Clinics of Cobalt Business Park, Unit 5, Silver Fox Way, Newcastle Upon Tyne, NE27 0QJ and an expert/s appointed by them.

I also authorise the release of medical records and any medical reports to Bodycare Clinics and their Instructing Solicitor/Insurance Company and/or rehabilitation, and other service providers as required in connection with my claim.
I confirm that this information is not required in respect of a claim for medical negligence against the doctor, health authority or its servants and agents.

5) I AM THE **PATIENT/PARENT OF THE ABOVE/LEGAL GUARDIAN** OF THE ABOVE (please select)
I have reviewed and understood the authorisation above

SIGNATURE | FULL NAME | DATE