



blackwell associates

**PROTECT MEDICAL
BWELL3**

Full Name: _____

Date of Birth: _____

The Medical Advisor at Blackwell Associates may approach your family doctor and if necessary the Specialist Practitioner involved in your care for further medical information if required?

Please tick as necessary Yes No

Name/Address of GP: _____

Name/Address of Specialist _____

Name/Address of Specialist _____

Name/Address of Specialist _____

Under the terms of the Access to Personal Files and Medical Reports Order (NI) 1991, do you wish to see the medical information before it is supplied to the Medical Advisor?

Please tick as necessary Yes No

Signature: _____

Date: _____

A note of your rights under the provisions of the Order is included for your information with this form. Please note this consent is valid for six months from the date of signature.

PROTECT MEDICAL

LL – GP/SP consent - April 2011 v1 - Uncontrolled when printing