



**CONSENT TO THE RELEASE OF MEDICAL INFORMATION  
TO THE MEDICAL ADVISOR (Capita Health Solutions)**

---

May the Medical Advisor 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

Under the terms of 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

Your Doctor / Specialist		
Name: _____	Address: _____	
		Postcode: _____
Name: _____	Address: _____	
		Postcode: _____
Name: _____	Address: _____	
		Postcode: _____
Name: _____	Address: _____	
		Postcode: _____
Name: _____	Address: _____	
		Postcode: _____

Please insert the following:

Your Full Name

\_\_\_\_\_

Your Date of Birth

\_\_\_\_\_

Your Signature

\_\_\_\_\_

Date

\_\_\_\_\_

**CAP 3**

*A note of your rights under the provisions of the Order is included for your information with this form.*