



WELLINGTON

Medical Practice

Private Work Request Form Only

Date:	
Patient's Full Name:	
Patient's Date of Birth	
Patient's Address:	Telephone (Home):
	Mobile:
	Email:

Details of Request:

Please do not use this form for prescription requests, they will not be processed

CONSENT

I consent to medical information about myself being released to:

.....
(Please specify yourself, the company you wish to receive the information or a third party, i.e family member)

Patient's Signature

Date

Consent is valid for a period of six (6) months

Please note: Information cannot be provided regarding a patient without that patient's written consent.

If you decide to cancel your request after you have paid for the work, you may still incur an administration fee of 15%

It may take up to 28 days from the date of payment for you to receive the information that you have requested.

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