

FORM OF AUTHORITY

REQUEST FOR DISCLOSURE OF HOSPITAL MEDICAL RECORDS

Name [of child]:

Address [of child]:

Date of Birth [of child]:

**Hospital(s)
Attended:**

- 1.
- 2.
- 3.

I,, am the parent/guardian of
[name of child]....., and under the
General Data Protection Regulations I hereby request and authorise you to
provide to NHS Resolution, its legal advisers and any experts nominated by
them, a full copy of all medical records, correspondence and imaging relating to
[name of child].....

.....
SIGNED BY [parent/guardian]

.....
DATED