

**Consent for Insurance report/claim or other fee service**

Please read this carefully.

I give consent to Albany House Medical Centre to disclose the minimum information required to complete the Non-NHS service I have requested.

**I understand that a deposit of £25:00 is required on request by cash**

**or cheque**, that fees are non-negotiable and that **an additional fee may be charged** if the work required to complete is more than the deposit taken. I also understand that deposits are non-refundable unless we are unable to complete the work.

**NOTE THAT, BECAUSE THIS IS LOW-PRIORITY WORK, IT MAY TAKE UP TO 21 working days TO TURN ROUND THIS REQUEST.**

Patient's full name (CLEARLY) .....

Signed: ..... Date: .....

Date of birth: ..... **CONTACT NUMBER** .....

If you are requesting this information on behalf of someone else please fill in the section below:

Name of person requesting (print CLEARLY): .....

**CONTACT NUMBER**.....

For under 16s, the patient must sign to indicate that they have given consent for us to disclose this information:

Patient's consent given: ..... Date: .....

Relationship of requestor to patient (eg parent/carer/etc): .....

Deposit taken:  
**MUST BE COMPLETED BY STAFF**

Date & Initial

**CONTACT NUMBER**.....

Taken by

Cash

Cheque

PTO

Please complete below the details of your request or attach the relevant information

.....

.....

.....

.....

.....

.....

.....

.....