Authorisation for disclosure of medical information relevant to employment

Name:		Date of birth:	
Address:			
Telephone No:			

To:			
Doctor's name:		Consultant's Name:	
Address:		Address:	
Telephone No:		Telephone No:	
		Hospital Reference No:	
Signature:		Dated:	

I hereby consent to a medical report being supplied in confidence to my employer. I understand my rights under the Access to Medical Reports Act 1988, and have read the summary of my principal rights under the Act attached to this form. I do / do not wish to have access to the medical report before it is supplied.			
Signature:		Dated:	