# Consent for a doctor's report form

Name:

Address:

Date of birth:

Doctor name:

Doctor address:

I give consent for my employer to get a medical report from my doctor.

☐ Yes

☐ No

I want to see a copy of the report before it is sent to my employer.

☐ Yes

☐ No

I confirm that if I do want to see a copy of the report, I will contact the doctor within 21 days of my employer requesting it.

I confirm I have read and understood my rights under the Medical Records Act 1988.

☐ Yes

☐ No

Signed:

Date: