Paid for Private Request

Section A: Requesters Information

First Name(s):	Surname:
Date of Birth:	
Home Address:	
Contact Number:	
Email address:	

Tick whichever of the following statements apply.

☐ I am the patient.

☐ I have been asked to act by the patient and attach the patient's written authorisation.

☐ I am acting in Loco Parentis and the patient is under age sixteen, and (is incapable of understanding the request) / (has consented to me making this request)*.
delete as appropriate.

☐ I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that (please supply your reasons below).

Note:
If no, you must provide the patient's written consent to release information along with photo ID, if over the age of 16.

Section B: Summary of Request

Please provide a description of what you require:

Section C: Please Tick Service Required

Confirmation of Registration / Private Sick Note / Private Script	£30.00	☐
Hepatitis B (Adult/Child) per dose	£40.00	☐
Private Medical Letter - e.g. (Insurance claim form, Fitness to travel form, housing, fitness to exercise, Holiday cancellation, questionnaire-not physically seeing patient, etc.)	£80.00	☐
Private Detailed Medical Report and where Dr needs to see the patient	£130.00	☐
Mental Capacity Assessment Form (Patient seen at practice)	£150.00	☐
Mental Capacity Assessment Form (Patient seen at home)	£250.00	☐
Public Carriage Office (PCO) Form – Dr to see patient Please Note: WE DO NOT DO VISION TEST – This will need to be done privately and will need to be completed prior to GP assessment Please Note: If any further information is required after the form has been processed will be charged at an additional £80	£130.00	☐
If none of the above, please attach the form, this will need to be verified by GP/General Manager (A member of the team will contact you back within 72 hours with the fee)		☐

Section D: Must Tick

Routine Service: *30 Days*	☐
Fast Track Service: 10 Working Days *(this does not include weekends or bank holidays)* ***An additional £30.00 plus the above fee charged***	☐

UPFRONT PAYMENT - NO REFUNDS

Section E: Declaration: Please note that we will only provide and support factual information at the discretion of the Medical Director, sign below to confirm you understand this statement.

Patient's/Requester Signature:	
Name of signed:	
Date:	
***Your information request will start from the date paid**	

Admin Staff to Complete <u>ALL FIELDS</u>:

Total Amount due:	£
Emis Number of patient:	
Patients Full Name:	
Patient ID Confirmation: Please state - *(Photo ID/ Passport/ Birth Certificate*	
Amount Paid:	
*Date Paid:	
Member of Staff payment taken by:	
Receipt Number:	

Section E: Doctor to complete

Completed ☐	Completed by**:**	Date: