

## **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 Requi	red				
Confirmation of Registration / Priv	e 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				£80.00	
seeing patient, etc.)				040000	
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					
Public Carriage Office (PCO) Form -	-				
Please Note: WE DO NOT DO VISION TEST – This will need to be done privately					_
				£130.00	
Please Note: If any further information is required after the form has been					
processed will be charged at an ad					
If none of the above, please attach	the form, this will ne	ed to be verifie	ed by GP/Ger	ieral	
Manager (A member of the team	will contact you back	within 72 hour	s with the fee	e)	
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					
Name of signed:					
Date:					
*Your info	ormation request will	start from the	date paid		
Admin Staff to Complete <u>ALL FIELD</u>	<u>S</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	<i>y</i> :				
Receipt Number:					
· <u></u>					
·					
Section E: Doctor to complete  Completed	Completed by:		Date:		