



**MEDICAL AUTHORITY**

**Patients Name** SHEILA ROSEMARY GREGORY

**Date of Birth** Code A

I hereby authorise the release of any medical document or record, howsoever held, by any health professional who has had any dealings with SHEILA ROSEMARY GREGORY

I also give my permission for any health professional who has had any dealing with SHEILA ROSEMARY GREGORY to make a statement to any police officer.

**Signed** Code A (next of kin.)

**Date** 15-10-04

For Office use only
Case R v
URN 44 / /0.. To be returned to