**Insert details of GP or healthcare professional**

**you would like us to contact:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Dr/Sir/Madam,

**Full name:**

**Date of birth:**

**Address:**

I have made an application to Headway- the Brain Injury Association for a Brain Injury Identity Card. I understand that Headway has contacted you to verify that I have sustained an acquired brain injury.

I hereby give my permission for you to share details of my acquired brain injury with Headway – the brain injury association in order that they can continue processing my application.

Thank you.

Yours faithfully,

***(Sign here)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**