**Request for Copy of My Medical Records**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Section 1 – Your Details | | | | | | | | | | | | | | | | | | | |
| Please make sure you use your formal name in this section | | | | | | | | | | | | | | | | | | | |
| Mr Mrs Ms Dr | | | | Other |  | | Surname | | |  | | | | | | | | | |
| First Name | | | |  | | | | | | | | | | | | | | | |
| Second Name | | | |  | | | | | | | | | | Other Initials | | |  | | |
| Address | | | |  | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | |
| Post Code | | | |  | | | | | | | | | | | | | | | |
| Date of Birth | | | |  | | | | | | | | | | | | | | | |
| Telephone Number | | | |  | | | | | | | | | | | | | | | |
| We will contact you on the above number to let you know when the records are ready to collect. Are you happy for us to leave a message at this number? (please tick) | | | | | | | | | | | | | | | Yes | | | No | |
| If the telephone number is a mobile phone, would you like us to update your records so that you receive text message appointment reminder and other health messages, communications and reminders from us? (please tick) | | | | | | | | | | | | | | | Yes | | | No | |
| Section 2 – Information you require | | | | | | | | | | | | | | | | | | | |
| 1. | Please provide me with copies of my medical records for the following period | | | | | | | | | | | | | | | | | | |
| From: | | |  | | | | | To: |  | | | | | | | | | | |
| 2. | Please provide me with copies of my entire medical records from my date of birth to date | | | | | | | | | | | | | | | Tick: | | |  |
| Section 3 – Signature | | | | | | | | | | | | | | | | | | | |
| Signed | |  | | | | | | | | | Date |  | | | | | | | |
| Please hand this form to the receptionist along with photographic ID. | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| For Practice Use ONLY | | | | | | | | | | | | | | | | | | | |
| Action | | | | | | Signed | | | | | | | Date | | | | | | |
| **Date request received** | | | | | |  | | | | | | |  | | | | | | |
| **Identity verified**  **Please list documents seen** | | | | | |  | | | | | | |  | | | | | | |
| **Data Checked** | | | | | |  | | | | | | |  | | | | | | |
| Patient advised ready to collect | | | | | |  | | | | | | |  | | | | | | |