**Request for Copy of My Medical Records**

|  |
| --- |
| 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 |  |  |