Data Protection Act – Request for Copies 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(s)				
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 – please complete 1,2 or 3				
1.	**Please provide me with copies of my medical records for the following period**			
From:		**To:**		
2.	**Please provide me with a print-out of my medical records that are held on computer**		**Tick:**	
3.	**Please provide me with copies of my entire medical records from my date of birth to date (to include any paper records as well as those held on computer)**		**Tick:**	
4.	**Please provide me with a specific hospital letter/report/result (please detail what is required):**		**Tick:**	

Section 3 – Signature			
Signed		**Date**	
Please hand this form to the receptionist along with 2 forms of ID (eg passport or photo driving licence plus utility bill or council tax bill)			

For Practice Use ONLY		
Action	**Signed**	**Date**
Identity verified **Please list documents seen**	1.	2.
Data Extracted		
Data Checked		
Patient advised ready to collect		