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						
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 – 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:	

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		