# *Request for Copies of My Medical Records*

| **Section 1 – Your Details** | | | | |
|---|---|---|---|---|
| **Please make sure you use your formal name in this section** | | | | |
| Mrs | Other | | Surname | |
| First Name | | | | |
| Second Name | | | Date of Birth | |
| Address | | | | |
| Telephone No | | | | |

| | | |
|---|---|---|
| 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 by ticking <u>one</u> of the boxes. Allow up to 20 days for completion of your request**

| | | |
|---|---|---|
| 1. | Please provide me with copies of my medical records for the following period<br>From: To: | Tick: |
| 2. | Please provide me with a copy of my test results. Please state which test result you require e.g. blood, x-ray, scans etc. and which dates. | Tick: |
| 3. | Please provide me with a print-out of my medical records that are held on computer | Tick: |
| 4. | Please provide me with a full patient summary (this includes a full list of medical problems, consultations and test results). | Tick: |
| 5. | Please provide me with a list of all my medical problems only | Tick: |
| 6. | Please provide me with a list of my immunisations/vaccination records | Tick: |
| 7. | Please provide me with copies of my entire medical records from my date of birth (or earliest date recorded) to date (to include any paper records as well as those held on computer) | Tick: |
| 8. | Please Provide me with a copy of my medical records relating to the incident specified below: | Tick: |
| 9. | Please provide me with a copy of my medical records relating to the condition specified : | Tick: |

| Section 3 – Signature | | | |
|---|---|---|---|
| Signed | | Date | |
| Print name: | | | |

**Please hand this form to the receptionist along with 2 forms of ID (e.g. passport or photo driving licence plus utility bill or council tax bill)**

**For Practice Use ONLY**

| Action | Signed | Date |
|---|---|---|
| Identity verified<br><br>Please list documents seen | 1. | 2. |
| Data Extracted | | |
| Data Checked | | |
| Patient advised ready to collect | | |