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 to ensure we have the correct contact details for you? (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		