

Subject Access Request for Copies of Personal Medical Record

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				

Processing your request may take up to 30 days. 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?	Yes	No
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Records should normally be collected from the practice in person. If you would like someone else to collect the copy of your medical record, enter their name here (please tell them they will need to bring a form of photo ID with them when they collect your record):

Collector Name: _____

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 from 2006 onwards (these are held on computer)	Tick:	
3.	Please provide me with copies of my entire medical records from my date of birth to date	Tick:	

Section 3 – Signature

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