

## **Data Protection Act – Request for Copies of My Medical Records**

| <b>Section 1 – Your Details</b>  |  |                |                       |
|--|--|----------------|-----------------------|
| Please make sure you use your formal name in this section  |  |                |                       |
| <b>Mr Mrs Ms Dr</b>  | <b>Other</b>   | <b>Surname</b> |                       |
| <b>First Name</b>  |  |                |                       |
| <b>Second Name</b>   |  |                | <b>Other Initials</b> |
| <b>Address</b>   |  |                |                       |
| <b>Post Code</b>   |  |                |                       |
| <b>Date of Birth</b>   |  |                |                       |
| <b>Telephone Number</b>  |  |                |                       |
| 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)   |  |                | <b>Yes</b>            |
| 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) |  |                | <b>No</b>             |
| 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) |  |                | <b>Yes</b>            |
| 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) |  |                | <b>No</b>             |
| <b>Section 2 – Information you require – please complete 1,2 or 3</b>  |  |                |                       |
| <b>1.</b>  | <b>Please provide me with copies of my medical records for the following period</b>  |                |                       |
| <b>From:</b>   |  | <b>To:</b>     |                       |
| <b>2.</b>  | <b>Please provide me with a print-out of my medical records that are held on computer</b>  | <b>Tick:</b>   |                       |
| <b>3.</b>  | <b>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)</b> | <b>Tick:</b>   |                       |
| <b>Section 3 – Signature</b>   |  |                |                       |
| <b>Signed</b>  |  | <b>Date</b>    |                       |
| 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)  |  |                |                       |

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