**We will process your request within 28 days of receipt**

|  |
| --- |
| **Information required between dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Relating to the medical condition(s)** |
| **Do you also require copies of correspondence/hospital letters we may hold? Yes/No**  |
| **Any other comments you may wish to make:** |
| Medical records will normally be supplied by secure (and encrypted) email.  |

Please note that you might be contacted by the Practice for further information or clarification about the request if needed using the contact information you have provided above.

By signing below, you indicate that you are the individual named above or the legal guardian of a child under 13yrs. The Practice cannot accept requests regarding your personal data from anyone else, including family members. We may need to contact you for further identifying information before responding to your request.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Print Name |  | Signed |  | Date  |
| D.O.B |  |

**Please hand this form into Reception**

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**For Practice use only**

**Please check request is complete and ID has been provided and note below**

|  |  |  |
| --- | --- | --- |
| Please ensure boxes ticked before records given to patients. |  | Form recorded as received Form signed off by GP Form recorded as completed  ID provided on collection Patient Signature on Collection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient identity verified by:Print name:Signature: | Date | MethodPhoto ID  Proof of residence  |