**Text, logo

Description automatically generated Request for Copy of Medical Records**

**As an alternative to requesting a copy of your medical records, you can request access to your online medical record by registering with the NHS App or speaking to our reception team.**

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| --- | --- |
| **Date of request** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details (for the medical record being requested)** | | | |
| Name |  | Date of birth |  |
| First line of address |  | | |

|  |  |
| --- | --- |
| **Requester Details** | |
| Requester Name |  |
| Relationship to patient |  |
| Telephone number |  |
| Email address |  |

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| **I would like a copy of my medical record (please tick ONE of the following)** |
| Copy of ALL medical records from …………..………….. to ……….……..……… (please insert dates) |
| Copy of medical records relating to a specific injury or condition (please describe below)  Details of injury/condition required:  …………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………  Dates required for this injury/condition: from ………………….. to ………..…..……… (please insert dates) |

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| --- | --- |
| **How would I like to receive this information?** | |
| **Please sign the right hand box to confirm the format required and that** **once these are released to me I understand that I am responsible for the security and confidentiality of these records** | |
| I consent for the medical record to be emailed to the email address above (this will be unencrypted) |  |
| I would like a paper copy (ID needed on collection) |  |

|  |  |
| --- | --- |
| **To be completed by a staff member at time of request (if requiring email) or on collection of printed copy** | |
| Name of staff member |  |
| Type of ID seen / verification method |  |
| Date medical records collected/emailed |  |

**This request will be passed to the medical admin team who will contact you on completion within 30 days**

**PLEASE NOTE THERE MAY BE A CHARGE FOR THIS SERVICE FOR REPEATED/EXCESSIVE REQUESTS**