

SUBJECT ACCESS REQUEST FORM
Request for Copies of My Medical Records

Section 1 – Your Details			
Please make sure you use your formal name in this section			
Title		Surname	
Forenames(s)			
Address			
Post Code		Date of Birth	
Telephone Numbers			
E-mail address:			
Would you like us to update your records so that you receive text message/email appointment reminder and other health messages, communications and reminders from us? (please tick)			Yes
			No
Section 2 – Information you require – <u>please complete either 1 or 2.</u>			
1.	Please provide copies of my medical records for the following period. These will be sent electronically to whoever has requested them.		
From:		To:	
OR			
2.	Please provide 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). These will be sent electronically to whoever has requested them.		Tick:
Section 3 – Signature			
Signed		Date	
Please hand this form in to reception along with 1 photographic form of ID (eg passport or photo driving licence). We will process the request within the statutory timeframe of one month once we have received the completed and signed form.			

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