**Skerryvore Practice**

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

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| Section 1 – Your Details | | | | | | | | | | | | | | |
| Please make sure you use your formal name in this section | | | | | | | | | | | | | | |
| Mr Mrs Ms Dr | | | |  | | Surname | | |  | | | | | |
| First Name | | | |  | | | | | | | | | | |
| Second Name | | | |  | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | |
|  | | | |  | | | | | | | | | | |
|  | | | |  | | | | | | | | | | |
| Post Code | | | |  | | | | | | | | | | |
| Date of Birth | | | |  | | | | | | | | | | |
| Telephone Number | | | |  | | | | | | | | | | |
| Email address | | | |  | | | | | | | | | | |
| 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)\* | | | | | | | | | | | | | Yes | No |
| Section 2 – Information you require – please complete 1 & 2 | | | | | | | | | | | | | | |
| 1. | Please provide me with copies of my medical records for the following period | | | | | | | | | | | | | |
| From: | | |  | | | | To: |  | | | | | | |
| 2. | Please tick which format you require the records to be produced | | | | | | | | | | | | Email | Paper |
| Section 3 – Signature | | | | | | | | | | | | | | |
| Signed | |  | | | | | | | | Date |  | | | |
| 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) | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| For Practice Use ONLY | | | | | | | | | | | | | | |
| Action | | | | | Signed | | | | | | | Date | | |
| **Identity verified**  **Please list documents seen** | | | | | 1. | | | | | | | 2. | | |
| **Data Extracted** | | | | |  | | | | | | |  | | |
| **Data Checked** | | | | |  | | | | | | |  | | |
| Patient advised ready to collect | | | | |  | | | | | | |  | | |

**Please ask patient to sign on collection of records**

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*\*Please note this request will take up to one month*