**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*