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| **Section 1 – Your Details** |
| **Please ensure you use your formal name in this section** |
| **Mr Mrs Ms Dr** | **Other** |  | **Surname** |  |
| **Forename** |  |
| **Middle name(s)** |  | **Date of Birth** |  |
| **Address** |  |
| **Post Code** |  |
| **Email Address** |  |
| **Phone Number** |  |
| **We will contact you on the above number when the records are ready. Are you happy for us to leave a message at this number? (Please tick)** | **Yes** | **No** |
|  |  |  |
| **Section 2 – Information you require – please complete below** |
| **1.** | **Please provide me with copies of my medical records for the following period:** |
| **From:** |  | **To:** |  |
| **2.** | **Please provide me with a print-out of specific records – please specify on a separate sheet (e.g. records relating to a specific condition or occurrence).** | **Tick:** |  |
| **3.** | **Please provide me with copies of my entire medical records from my date of birth to date (including paper records).** | **Tick:** |  |
| **4.** | **It would be helpful if you can provide details of what the information will be used for?** |  |  |
| **Section 3 - Signature** |
| **Signed** |  | **Date** |  |
| **Please hand this form to a receptionist or email back to Kingsmills Medical Practice with photo ID (Passport or Driving Licence)** |

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| **For Practice Use ONLY** |
| **Action** | **Signed** | **Date** |
| **Identity Verified** |  |  |
| **Documents Seen: (Enter)** |  |  |
| **Data Extracted:** |  |  |
| **Data Checked:** |  |  |
| **Patient advised ready to collect:** |  |  |
| **3rd Party Collection Yes/No:** |  |  |
| **Completed form scanned to patient Docman:** |  |  |

***NOTE: Records will NOT be released to Third Parties unless written authorisation is given by the Patient in advance and the named person produces photo ID when collecting the records***