|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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)** | | | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| **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***