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| **Section 1 – Your Details** |
| **Please ensure you use your formal name in this section** |
| Mr Mrs Ms Dr | First Name | Surname |
| Middle name (s) |  | Date of Birth |  |
| Address |  |
| Postcode |  |
| Email Address |  |
| Contact Number |  |
| We will contact you on the number provided when records are ready. Are you happy for us to leave a message at this number? ( **Please tick**) | Yes | No |
| **If you are requesting copies of medical records on behalf of someone over the age of 16:** |
| Full Name |  |
| Relation  |  |
| I …………………………………. Consent to ……………………………….. Requesting medical records on my behalf.Signature……………………………………….. Date: …………………………………. |
| **Section 2 – Information you require – Please Complete only one.** |
| 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 ort occurrence). | Tick |
| **OR**  |  |  |
| **3.** | Please provide me with copies of my entire medical records from my date of birth to date (including paper records) | Tick: |
| Reason for requesting medical records |  |
| **Section 3 - Signature** |
| **Signed** | **Date** |
| **I consent to see any sensitive information that I may not currently be aware of** | **Tick:** |
| **Please hand this form to a receptionist or send the form via email to nhsh.gp55889-reception@nhs.scot** |

**NOTE: Records will NOT be released to third parties unless written authorisation is given by the patient in advance.**

**Please note we have 30 days in which to complete this request, please do not contact the practice until a week before that time has elapsed to make enquiries.**

Medical Records will sent by email. We do not provide paper copies of medical records.

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