

REQUEST FOR MEDICAL RECORDS RELEASE FORM

**Date:**

Dear Sir/ Madam,

In accordance with the Data Protection Act 2004, I kindly request a copy of my medical records held by yourselves.

**Patient Information: Note Fields with an \* are compulsory**

**\*Please provide a copy of your ID card**

|  |  |
| --- | --- |
| \*Name |  |
| \*Date of Birth |  |
| \*Address |  |
|  |
| \*Telephone  |  |
|  Mobile |  |
|  Email |  |
| GHA Number |  |

**\*Please let us know whether you would like the notes via email or you would like to collect them.**

I request the following information:

|  |  |  |
| --- | --- | --- |
| Records Name | \* Please provide dates of medical tests, etc.. | \*Tick appropriate box |
| Hospital Notes |  |  |
| Pathology **\*\*\*\*\*** |  |  |
| A&E Notes |  |  |
| Primary Care Notes |  |  |
| Immunisation  |  |  |
| Radiology **\*\*\*\*\*** |  |  |
| Physiotherapy Notes |  |  |
| Maternity Notes |  |  |
| Psychiatric Notes |  |  |

**\*\*\*\*\*The results must be verbally given to you by your doctor, before we can release copies.**

**I understand that a copy of my records may take up to 28 days.**

Patients Signature: (pen signature)

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorise\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to collect my medical records. (Copy of Id or passport of authorised)**

**Tel: +350 20007364 / +350 20007361
email: releaseofrecords@gha.gi**