This form must be completed for all request for copies of patient records and passed to the Admin Team immediately for processing.

I, (Print name) ………………………………………………………………………

Of (Address) …………………………………………………………………………………………….

…………………………………………………………………………………………………………….

Date of Birth………………………request access to the information you hold in my medical records. I understand that this information is normally provided free of charge and must be supplied to me within 30 days of the date below, although I will be notified if it will take longer.

I understand a fee will apply if I request further copies of information already provided.

**WHAT COPIES OF YOUR MEDICAL RECORD DO YOU NEED?**

* Tick required option(s) from 3 below

□ HEALTH RECORDS - ALL FROM : …../……./….. and TO: ……./……/……..

□ HEALTH RECORDS **ONLY** RELATING TO THE FOLLOWING CONDITION(S)

………………………………………………………………………………………………………..

□ A SPECIFIC ITEM E.g. X-RAY / SCAN / FIT NOTE / IMMUNISATIONS HISTORY

………………………………………………………………………………………………………….

**OR TICK BELOW**

□ **ALL** HEALTH RECORDS FROM BIRTH

Signature……………………………………………….. ….. Date…………….……………………

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