|  |  |
| --- | --- |
| **Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |

Can I please request a copy of the following from my medical records:

|  |  |
| --- | --- |
|  | Please advise more detail |
| Result |  |
| Letter |  |
| Summary Print out |  |
| Other |  |

Signature of applicant:……………………………………………… Print Name ……………………………………………..

Date of request ……………………………………..

***Please note that we cannot always complete your request straight away. Please allow 7 working days before collection.***

*For surgery use only:*

*Date of application ………………………………………….. Received by ………………………………………………*

*Request approved by GP - YES/ NO (please state GP)………………………………………………………..*

**Copy received by patient:**

Patient Signature…………………………………………………………… Date…………………………………………………

EMIS 4547a\ Z \shared staff folder\forms for reception\patient request for items from medical records.