|  |  |
| --- | --- |
| Patient’s Full Name |   |
| Address |   |
|   |
| Telephone number |   | Mobile  |   |
| Date of Birth  |   |
| I am requesting access to:Review Records only [ ]  Obtain copies of Records [ ]  |
| Dates associated with request(e.g. date of treatment, consultation) |  |
| If requesting copies, please describe the reason for the request. | [ ]  Further Medical care [ ]  Personal use [ ]  Insurance [ ]  Legal  |
| Describe the information you are requesting to view or obtain copies of:I certify that this request to access health information is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that if I need to obtain hard copies there may be a charge of up to £50 associated with such copies. **Signature of patient/Legal representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****If legal representative, print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | [ ]  Discharge summary [ ]  Test Results[ ]  Medication [ ]  Immunisations[ ]  Consultation [ ]  Hospital letter[ ]  Brief Summary [ ]  Entire RecordsOther: |

**GP NOTE** I have reviewed the medical record(s) to determine if they contain information relative to psychological or psychiatric problems which, if revealed to the patient is reasonably likely to endanger the life or physical safety of the individual or another person.

**These portions of medical record(s)** [ ]  **May be released to the patient**

 [ ]  **May NOT be released to the patient**

**GP Signature ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GP NOTE** I have reviewed the medical record(s) to determine if they contain information relative to psychological or psychiatric problems which, if revealed to the patient is reasonably likely to endanger the life or physical safety of the individual or another person.

**These portions of medical record(s) May be released to the patient**

 **May NOT be released to the patient**

**GP Signature ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**