|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 Records  Other: | | |

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**