Bennochy Medical Centre

Data Protection Act – Request for Copies of My Medical Records

Section 1 – Detail of the person whose records are being requested						
Please make sure the formal name is used in this section						
Mr Mrs Ms Dr	Other		Surname			
Forename					Other Initials	
Address						
Post Code			Date of Birth			
Telephone Number						

We will contact you on the above number to let you know when the records are ready to collect. Are you happy for us to leave a message at this number? (please circle)	Yes	No
If the telephone number is a mobile phone, would you like us to update your records so that you receive text message appointment reminder and other health messages, communications and reminders from us? (please circle)	Yes	No
I received the leaflet "How to request GP Records & Other personal information"	Yes	No

Section 2 – Information you require – please complete 1,2 or 3			
1.	Please provide me with copies of my medical records for the following period From: To:	Tick	
2.	A brief summary showing recent medication, the last few consultation notes along with a list of any serious problems (procedures/diagnoses).	Tick	
3.	Please provide me with copies of my entire medical records from my date of birth to date (to include any paper records as well as those held on computer)	Tick:	
4.	I do not want copies, but I would like to view my records	Tick:	
5.	Other, please provide details:		

Section 3 – Further Information
It would be helpful if you can provide details of what the information will be used for in the box below:
Please use the space below for further information that you feel is relevant to this application:

Section 4 – Declaration			
I declare that the information given by me in sections 1-3 is correct to the best of my knowledge and that I am entitled to apply for this information. Please tick appropriate box:			
I am the patient		Tick:	
If you are the patient, please sign and date below:			
Signed		Date	
Please hand this form to the receptionist along with 2 forms of ID (eg passport or photo driving licence plus utility bill or council tax bill, dated in the last 3 months)			
OR			
I have been appointed by the court to manage the affairs of the patient and attach relevant documentation		Tick:	
I am acting on behalf of the patient and the patient and I have completed the authorisation (section 5)		Tick:	
I am the deceased patient's representative and attach confirmation of my status		Tick:	
I have Welfare Power of Attorney for this patient and attach relevant documentation		Tick:	
Other, please specify:			

Section 5 – Authorisation			
If you are not the patient:			
Name:			
Address:			
Contact Phone Number			
Relationship to Patient:			
Signed		Date	
Patient to read – please sign to indicate that you are happy for your representative to collect your medical information, and that you are aware that they will have access to all of the medical information you have requested. Your representative must bring in 2 forms of ID (eg passport or photo driving licence plus utility bill or council tax bill, dated in the last 3 months) for them and for you the patient.			
Signed		Date	
Please return this form to Secretary, SAR, Bennochy Medical Centre, 65 Bennochy Road, Kirkcaldy, Fife, KY2 5RB. Remember that you will need to have your ID verified at the Practice.			

For Practice Use ONLY		
Action	Signed	Date
Identity verified Please list documents seen	1.	2.
Data Extracted		
Data Checked		
Patient advised ready to collect		
Date Received/Consent Verified	Date to be completed by	Date completed

Due to the sensitive content of medical records, strict confidentiality is strongly advised, therefore it is advisable for patients and/or their representatives to collect any copies of medical information in person, from the practice.