

# Access to Medical Records

Fields marked with an asterisk (\*) are compulsory.

Please use this form to give consent for access to your medical record.

\*Date

\*Practice Name

## Patient Details

\*Surname

\*Forename(s)

\*Date of Birth  NHS Number

## Medical Record Request

\*Please provide the reason for which you are requesting to receive a copy of your Medical Records.

\*Patient Signature