Request form for Access to Medical Records

Access Request for Medical Records

I wish to obtain a copy of the medical record held at:

Practice

Name of Doctor	
Address of practice	

Patient

First Name	
Family Name	
Date of Birth	
Address	
Signature	
Date	

For Practice Use Only:
Date request received:
Method of identification:
Date record provided:
Person managing access request:

Notes:
No fee is chargeable for providing a copy of the medical record. It is important for the practice to verify the identity of the person making an access request or providing an access authorisation.