Park Road Practice - Access to Medical Records

Patient Name	
DOB	
Address	

Details of person wishing to access records (if different to above)

Name	
DOB	
Address	
Relationship to patient	

Please select from the below what you require

I am the patient and will provide photographic ID on arrival to view my records & when collecting any copies of records	**Photographic ID seen: (please state ID and Sign)** ***– Staff only***
I have been asked to act on behalf of the patient and attach the patient's written authorisation we may contact the patient to verify.	**Please sign if applicable**
I have a claim arising from the patient's death and wish to access information relevant to this claim and will provide consent from any relevant parties and ID when collecting records	**Please sign if applicable**
I would like copies of my entire medical record & will provide ID when collecting records	Yes / NO
I Would like copies of electronic records & will provide ID when collecting records	YES/ NO

I would like copies of my records between specific dates as detailed & will provide ID when collecting records	YES/NO
I would like copies of X Ray	YES/NO
I would like a copy of my blood results from:	YES/NO
I would like a copy of my referral/s	YES/NO
I would like a copy of my immunisations record	YES/NO
I would like a copy of my BP readings	YES/NO

Patients Signature	
Date	

Staff only:	
Date Information Given	
Date noted on Records	

Declaration: I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the General Data Protection Regulations 2018