REQUEST FOR MEDICAL RECORDS RELEASE FORM

Date:

Dear Sir/ Madam,

In accordance with the Data Protection Act 2004, I kindly request a copy of my medical records held by yourselves.

Patient Information: Note Fields with an * are compulsory

*Please provide a copy of your ID card

*Name	
*Date of Birth	
*Address	
*Telephone	
Mobile	
Email	
GHA Number	

I request the following information:

Records Name	* Please provide dates of medical tests, etc..	*Tick appropriate box
Hospital Notes		
Pathology		
A&E Notes		
Primary Care Notes		
Radiology		
Physiotherapy Notes		
Maternity Notes		
Psychiatric Notes		

I understand that a copy of my records may take up to 28 days.

Patients Signature: _____ (pen signature)

I _____ authorise_____ to collect my medical records.
(Copy of Id or passport of authorised)

Tel: +350 20007364 / +350 20007361

email: releaseofrecords@gha.gi