



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	

***Please let us know whether you would like the notes via email or you would like to collect them.**

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		
Immunisation		
Radiology *****		
Physiotherapy Notes		
Maternity Notes		
Psychiatric Notes		

*******The results must be verbally given to you by your doctor, before we can release copies.**

I understand that a copy of my records may take up to 30 days.

Patients Signature: _____ (pen signature)

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

Tel: +350 20007364 / +350 20007361 / +35020007067

email: releaseofrecords@gha.gi