**ACCESS REQUEST FOR MEDICAL RECORDS**

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

**PRACTICE DETAILS:**

|  |  |
| --- | --- |
| Name of Practice: | COLLEGE HEALTH SERVICES, TRINITY COLLEGE |
| Name of General Practitioner: |  |

**PATIENT DETAILS:**

|  |  |
| --- | --- |
| 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 records. It is important for the Practice to verify the identity of the person making an access request or providing an access authorisation.