ACCESS REQUEST FOR MEDICAL RECORDS

TO BE TRANSFERRED TO OTHER PRACTICE

I, _____

(Please print your name)

Address _____

Date of Birth _____ ID Number _____

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

TRINITY COLLEGE HEALTH SERVICE, PRINTING HOUSE SQUARE, TRINITY CAMPUS, D02 DP29

Signed _____ Date _____

NAME & ADDRESS OF NEW GP WHERE RECORDS CAN BE SENT TO (IF KNOWN):

_____

For Practice use only:-

Date Request Received _____ Date record provided _____

Method of I.D. from patient _____ Person managing 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.