**The Vauxhall Practice**

**Patients must complete this form when requesting copies of documents from their medical records for onward transmission to consultants, for their own records, or for any other reason.**

**\*PLEASE ALLOW AT LEAST 5 WORKING DAYS FOR REQUESTS TO BE PROCESSED.\***

I hereby request a copy of the following document/s from my medical records (please tick as appropriate):

|  |  |
| --- | --- |
|  | Blood Test/Investigation Result (Please Specify Below) |
|  |
|  | Letter from Hospital Consultant (Please Specify Below) |
|  |
|  | Other (Please Specify Below) |
|  |

The Reason I require this information is (Please state below):

I accept full responsibility for the security of this document once it has been removed from the Practice premises

Signed: Date:

Print Name:

Date of Birth:

**AUTHORISED BY:……………………………….** **DATE: ……………………………….**

**ACTIONED BY: ……………………………….**