Aviemore Medical Practice
Muirton, Aviemore, PH22 1SY • www.aviemoremedical.co.uk • T 01479 810258 • F 01479 810067
Dr Gilly Kirkwood • Dr Alistair Appleby • Dr Michelle Delap • Dr Jon Williams • Dr Julie Murdoch • Dr Chris Robinson • Dr Gemma Munro

Request for Access to Health Records

Section 1: Details of the patient

First Name: _____

Surname: _____

Date of Birth: _____

Registered Address: _____

Address Line 2 _____

City _____

County _____

Postal Code _____

Current address if different from above:

Current Address: _____

Address Line 2 _____

City _____

County _____

Postal Code _____

Daytime Contact Number: _____

Section 2: What information is required?

Please be aware that if you request a full copy of your medical records your GP will have to go through your records and redact information as per GDPR guidelines which can take a GP up to 2 hours to complete. There are several ways to obtain medical information which may be better for you and easier for your GP. Please be as specific as possible in your request so that we can limit the time that your GP spends on the administration of your medical record.

Please select from the following options:

- ☐ A DWP/PIP information summary report only
- ☐ A paper copy of the full record
- ☐ To view your health records
- ☐ A paper copy of records for date range

  From _____ to _____
- ☐ A letter or statement from a GP
- ☐ Other (please specify below)

  _____

  _____

  _____

Section 3: What will the information be used for?

Please give full details of what the information will be used for:

_____

_____

_____

_____

_____

_____

_____

Section 4: Further information

Please use the space below for further information you feel is relevant to this application:

_____

_____

_____

_____

_____

_____

Section 5: Declaration

I declare that the information given by me in sections 1-4 is correct to the best of my knowledge and that I am entitled to apply for this information.

Please tick appropriate box:

- ☐ I am the patient
- ☐ I have been appointed by the court to manage the affairs of the patient and attach relevant documentation
- ☐ I am acting on behalf of the patient and the patient has completed the authorisation (Section 6)
- ☐ I am the deceased patient's representative and attach confirmation of my status
- ☐ I have Welfare Power of Attorney for this patient and attach relevant documentation
- ☐ Other (please specify below)

_____

_____

_____

Patient/Applicant Name: _____

Patient/Applicant Signature: _____

Address if different from details in Section 1:

Street Address: _____

Address Line 2 _____

City _____

County _____

Postal Code _____

Section 6 – Patient Authorisation

Please ignore this section this section if you are requesting your own health records/personal information

I authorise Aviemore Medical Practice to release the information requested to:

_____

Whom I have given consent to act on my behalf.

Patient Name: _____

Patient Signature: _____

Please return this form together with a copy of your photographic ID and relevant documentation to either:-

Aviemore Medical Practice, Muirton, Inverness-shire, PH22 1SY or

Email: nhsh.gp55911-admin@nhs.scot

_____

Confirmation of identity (OFFICE USE ONLY)

ID checked/Patient verified

Patient verified by _____ Date _____