



Patient NHS Requests

Section A: Requesters Information

First Name(s):	Surname:
Date of Birth:	
Home Address:	
Contact Number:	
Email address:	
<p>Tick whichever of the following statements apply.</p> <p><input type="checkbox"/> I am the patient.</p> <p><input type="checkbox"/> I have been asked to act by the patient and attach the patient's written authorisation.</p> <p><input type="checkbox"/> I am acting in Loco Parentis and the patient is under age sixteen, and (is incapable of understanding the request) / (has consented to me making this request)*. *delete as appropriate.</p> <p><input type="checkbox"/> I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that (please supply your reasons below).</p> <p>Note: <i>If no, you must provide the patient's written consent to release information along with photo ID, if over the age of 16.</i></p>	

Section B: Summary of Request

Please provide a description of what you require:

Section C: Please Tick Service Required

Copy of Electronic Record To be emailed to you and you are happy to be sent to your personal email account	Free	<input type="checkbox"/>
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Online Access To Documents From External Sources (User must have an ACTIVE patient online access account)	Free	<input type="checkbox"/>
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Section D: Must Tick

Processed within 30 Days - FREE	<input type="checkbox"/>
Fast Track Service: 10 Working Days <i>(this does not include weekends or bank holidays)</i> £30.00	<input type="checkbox"/>

UPFRONT PAYMENT - NO REFUNDS

Section E: Declaration: Please note that we will only provide and support factual information at the discretion of the Medical Director, sign below to confirm you understand this statement.

Patient's/Requester Signature:	
Name of signed:	
Date:	
*Your information request will start from the date requested and can take up to 30 days to process	

Admin Staff to Complete ALL FIELDS:

Amount Due:	Free <input type="checkbox"/>	£30.00 <input type="checkbox"/>
EMIS Number:		
Patients Full Name:		
Patient ID Confirmation: Please state - <i>(Photo ID/ Passport/ Birth Certificate)</i> Please write down the applicable number		
Amount Paid (if applicable):		
*Date requested:		
Member of Staff taken request:		
Receipt Number (if applicable):		
Please explain to patient it will take up to 30 days for the request to be fulfilled.		

Section F: Doctor to complete

Completed <input type="checkbox"/>	Completed by:	Date:
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