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MEDICAL RECORDS REQUEST FORM

In line with Data Protection legislation, you are entitled to obtain copies of information we hold about you. In order for us to comply with your request please supply the following information:

Full Name.....

Date of Birth.....

Address.....

Phone number (in the event we need to contact you).....

Details of exactly what information is required.....

.....

Signed:.....

Name of person collecting.....

If you require copies in relation to legal, benefit or employment purposes you may not be aware there are longstanding processes in place to allow the appropriate agencies to obtain this information (with the appropriate consent) which avoids a direct request by the patient. Please do not request information to be sent to a third party as we are unable to do this. You will need to collect the records in person from the surgery along with identification.

PRACTICE USE ONLY

Date received

Date Completed

I.D. checked