**SPINNEY HILL MEDICAL CENTRE**

 **Dr S Sian - Dr A Raj - Dr A Joshi - Dr R Amin - Dr A Shah - Dr R Choudhary – Dr R Thakor – Dr A Sinha**

 **Main Surgery Branch Surgery**

 143 St Saviours Road, Leicester, LE5 3HX 132 Doncaster Road, Leicester, LE4 6JJ

 Tel: 0116 482 7140 Tel: 0116 482 7142

**REQUEST FOR PRIVATE WORK/MEDICAL RECORDS**

**TO BE CARRIED OUT BY THE GP PRACTICE**

|  |
| --- |
| **PATIENT DETAILS** |
| **Title** |  | **Any Previous** **Surname (s)** |  |
| **First Name** |  | **Town and Country of Birth** |  |
| **Surname** |  | **NHS No.****(If Known)** |  |
| **Gender** | **Male Female** | **Home Address**  |  |
| **Date of Birth**  |  |
| **Home Telephone No.** |  |
| **Mobile No.** |  | **Email Address**  |  |

**PLEASE CHOOSE FROM THE FOLLOWING OPTIONS:**

 **Factual Letter Request**

**CONDITONS**

**Who should the letter/report be addressed to?**

* **Organisation/Company Name:**
* **Recipient's Full Name & Title (if known):**
* **Full Postal Address of Recipient:**

 **Brief Summary**

 **Full Copies of Medical Records**

 **Copies of Medical Records from a certain period of time (From………….to ……………..)**

**I understand that once the information has been released, the GP practice is not responsible for the security of this data.**

|  |  |
| --- | --- |
|  | **I am the patient > Signature of Patient : …………………………** **Date: …………………………….** |
|  | **I have been asked to act by the patient >****Full Name: ……………………………………… Relationship: …………………..** **Contact Number: ……………………… Date: …………………………..** |
|  | **I am acting in loco parentis and the patient is under the age of 16 and** **(is capable of understanding of the request) has consented to my making this request.** |
|  | **I am the deceased patient’s personal representative and attach confirmation of my appointment. Full Name: ……………………………………… Relationship: ………………….. Contact Number: ……………………… Date: …………………………..** |
|  | **I have a claim arising from the patient’s death and wish to access information to my claim on the grounds that: ……………………………………….** |

|  |
| --- |
|  **Staff to complete**  |
| **Date Consent Form Accepted:** | **Completed by Staff:** |
| **Date of Payment Received:** | **Fees:** |