



**Subject Access Request for Medical Records**

**Patient Name**.....

**Date of Birth**.....

**Guernsey Address**.....

.....**Post Code**.....

**Contact Telephone Number**.....

**Name of Doctor**.....

**Patient of: St Sampson's / L'Aumone / Frances House** (delete as appropriate)

*Please tick box as applicable*

I would like to request a copy of my full medical records

I would like to request a copy of my partial medical records

(Partial records) dated from..... until.....

***Please note IslandHealth has 30 days from the date we receive your request in which to complete your medical record request.***

***IslandHealth does not take responsibility for this copy of your medical records after they have been collected from the surgery.***

**Signed**..... **(Patient)**

**Print Name**.....

**Date**.....

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For Office use only: - **Must be completed by staff member receiving the form**

Date Received..... Received by.....(PLEASE PRINT NAME)

Scanned.....