ST MARTIN SURGERY

AUTHORISATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, …… hereby authorise the disclosure of information from my Medical Health Records.

Patient Information:

Patient Name:…….. D.O.B……..
Address:……

Information Requested:

……
……
……

Purpose of Release:

……
……
……

The Information is to be Provided to:
Name of Person/Organisation……..
Address:……
Phone Number:…… E-mail address:……

I would like my records to be sent via (PLEASE TICK THE APPROPRIATE BOX):

Post	☐
Personal Email*	☐
Transfer electronically to a new GP surgery overseas*	☐
Pick up copies of records from the Practice	☐

*please note that it may not be possible to send your medical records electronically if the file is too large.

…… ……
Patient/Patient's authorised Representative Signature Date

…… ……
Print Name of Patient/Patient's authorised Representative Relationship of Patient (If not the Patient)

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. If medical records are to be sent electronically, it is the full responsibility of the recipient to provide a secure email address to which to send the medical records to.