IslandHealth
Committed to Patient Care Since 1894

Accredited by CHKS
Insight for better healthcare

Subject Access Request for Medical Records

Patient Name..

Date of Birth..

Guernsey Address...

……………………………………………………………………Post Code……………………………

Contact Telephone Number..

Email Address…………………………………………………………………………………….

Name of Doctor...

Patient of: St Sampson's / L'Aumone / Town (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..................................

Notes are for my own personal use: YES □ NO □

I am forwarding notes onto someone else: YES □ NO □

Notes are being forwarded to: ....

I am leaving the practice: YES □ NO □

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)

Date……………………………….

Print Name …………………………………………………….

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

Date Received...Received by……………………………………………(Please Print Name)

Scanned..