

**ACCESS TO MEDICAL RECORDS  
CONSENT TO VIEW MEDICAL RECORDS**

I understand my rights under the Data Protection Act 1998 to apply for access to my medical records.

I hereby request access to:

**A) my medical records between the following dates:**

From..... To.....

OR

**B) my whole medical records**

(delete as appropriate)

Copy of this consent will have the validity of the original.

Signature \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

**You MUST bring proof of your identity, in the form of a photo driving licence or passport, with you when you attend your appointment for viewing.**