\_\_\_\_\_\_\_\_\_\_\_\_\_Request for Medical Records\_\_\_\_\_\_\_\_\_\_\_\_

**Date: / /**

**To:** *(Former GP)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Regarding***: (Patient Details)*

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: / /**

**The above named has transferred to this practice.**

**They have asked me to request copes of medical files.**

**We would be grateful if you could forward these records at your earliest convenience.**

**Patient’s Consent:**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request Lakeshore Medical Centre to obtain my Medical Records.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_