REQUEST FOR RECTIFICATION OF A HEALTH RECORD

Date of Request		Patient Name	
Date of Birth		NHS Number	
Are you the Patient?	Yes/No	Contact Number	
If no, please indicate your name and relationship to the patient			

Please note, we can only accept third party requests for children or from individuals who have Lasting Power of Attorney (LPA) for the patient. Identity will need to be confirmed by photographic evidence or two forms of written proof of address.

Date of Error			Area of concern (please indicate)			
Diagnosis		Consultation		Medication		
Personal Details		Other (please specify)				

Please explain your reason for this request and details of rectification required:

Date of Error			Area of concern (please indicate)			
Diagnosis		Consultation		Medication		
Personal Details		Other (please specify)				

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Personal Details		Other (please specify)				

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Date of Error			Area of concern (please indicate)			
Diagnosis		Consultation		Medication		
Personal Details		Other (please specify)				

Please explain your reason for this request and details of rectification required:

Signature		Print Name	

Proof of identity confirmed ☐ Evidence Seen: ……………………………………………………………………………………