**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 must have written and signed consent from the patient giving permission for you to make this request on their behalf. (if this form is for you, you do not need to provide further consent)* |
|  |
| Date of Error |  | Area of concern (please indicate) |
| Diagnosis |  | Consultation |  | Medication |  |  |
| Personal Details |  | Other (please specify) |  |
| Please explain your reason for this request: |
|  |
| Date of Error |  | Area of concern (please indicate) |
| Diagnosis |  | Consultation |  | Medication |  |  |
| Personal Details |  | Other (please specify) |  |
| Please explain your reason for this request: |
|  |
| Date of Error |  | Area of concern (please indicate) |
| Diagnosis |  | Consultation |  | Medication |  |  |
| Personal Details |  | Other (please specify) |  |
| Please explain your reason for this request: |
|  |
| Date of Error |  | Area of concern (please indicate) |
| Diagnosis |  | Consultation |  | Medication |  |  |
| Personal Details |  | Other (please specify) |  |
| Please explain your reason for this request: |
|  |
| Signature |  | Print Name |  |