Darwen Healthlink
An essential link in your healthcare

REQUEST FOR RECTIFICATION OF A HEALTH RECORD

Date of Request			
Patient Full Name		**NHS Number**	
Date of Birth		**Contact Number**	
Are you the Patient? If no, please indicate your name and relationship to the patient;			
Has the patient given consent for you to contact the surgery?		**Has the patient filled in a consent form the surgery?**	

Area of Concern
Please indicate:

Diagnosis	Consultation	Medication	Personal Details	Other
☐	☐	☐	☐	☐

Please explain the reason for request below;

Patient Signature:	
Patient Representative Signature (if applicable)**:**	
Please print:	
Patient Representative Contact Number (if applicable):	

FOR PRACTICE USE ONLY:

Received by:	Date Stamp: