# APPLICATION FORM FOR ACCESS TO HEALTH RECORDS

**in accordance with the General Data Protection Regulation (GDPR) DATA SUBJECT ACCESS REQUEST**

This form must be completed in blue or black ink and signed in order for us to process your request.

## Section 1: Patient details

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** |  | **Maiden name** |  |
| **First Name** |  | **Title****(i.e. Mr, Mrs, Ms, Dr)** |  |
| **Date of birth** |  | **Address:** |
| **Telephone number** |  |
| **NHS number****(if known)** |  | **Postcode:** |  |

**Section 2: Record requested**

|  |
| --- |
| **Please provide me with a copy of records between the dates specified below:** |
| **Please provide me with a copy of records relating to the incident specified below:** |
| **Please provide me with a copy of records relating to the condition specified below:** |
| **Please provide me with a copy of records of all electronic records held:** |

**Section 3: Sending options**

Please state whether you consent to us sending your record by email or whether you prefer to collect the copies yourself.

* I consent to Chadsfield Medical Practice emailing my medical record to me at the email address specified above.

### Or

* I wish to collect the copies of my medical record from the Surgery.

## Section 4: Details and declaration of applicant

Please enter details of applicant if different from Section 1

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Title****(Mr, Mrs, Ms, Dr)** |  |
| **Forename(s)** |  | **Address** |
| **Telephone number** |  |
| **Capacity in which requesting (Name of****Organisation)** |  |

### Declaration

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the GDPR.

Please tick:

* I am the patient
* I have been asked to act by the patient and attach the patient’s written authorisation / consent
* I have full parental responsibility for the patient and the patient is under 11 years of age
* I have full parental responsibility for the patient and the patient is between 12 and 17 years of age but is incapable of understanding the request (to be assessed by GP)
* I am acting *in loco parentis* and the patient is incapable of understanding the request
* I have been appointed by the court to manage the patient’s affairs and attach a certified copy of the court order appointing me to do so
* I am the deceased person’s Personal Representative and attach confirmation of my appointment (Grant of Probate/Letters of Administration)
* I have written, and witnessed, consent from the deceased person’s Personal Representative and attach Proof of Appointment
* I have a claim arising from the person’s death (Please state details below)

Signature of applicant: .....................................................Date: ………………………..

### You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

**Section 5: Proof of identity and evidence**

**Evidence of the patient’s identity will be required.**

**Please attach copies of the required documentation to this application form. Examples of required documentation are:**

|  |  |  |
| --- | --- | --- |
|  | **Type of applicant** | **Type of documentation** |
| **A** | An individual applying for his/her own records | One copy of identity required,e.g. copy of passport or driving licence, plus one copy of a utility bill or medical card, etc. |
| **B** | Someone applying on behalf of an individual (Representative) | One item showing proof of the patient’s identity and one item showing proof of therepresentative’s identity (see examples in ‘**A’** above) |
| **C** | Person with parental responsibility applying on behalf of a child | Copy of birth certificate of child & copy of correspondence addressed to person with parental responsibility relating tothe patient |
| **D** | Power of Attorney/Agent applying on behalf of an individual | Copy of a court order authorising Power of Attorney/Agent plus proof of the patient’s identity (see examples in ‘**A’**above) |

**Additional notes**

Before returning this form, please ensure that you have:

1. Signed and dated this form
2. enclosed proof of your identity
3. enclosed documentation to support your request (if applying for another person’s records)

Incomplete applications will be returned; therefore please ensure you have the correct documentation before returning the form.