Personal Request for Access to Health Records

GDPR - For use after 25 may 2018

This form is for access to full records or large portions of records. A simple form is available for test results.

Section 1: Patient's Details

Name _____ D.O.B. _____

Address. _____

_____

_____

Contact Tel. Number._____

(Affix Patient label here)

Please provide as much information as possible to help us locate the section of your record that you want. It would help us to find the right records if:

- You can give us the date/s of the care that you are interested in
- The names of the health professional/s who looked after you
- Where you were cared for e.g. at home, health centre, hospital, ward or department
- What your illness, test, letter or treatment was

Details

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Redaction of Records

Please note that we need to redact (Black out) any 3rd party information before supplying the medical records.

Fees

Under the EU General Data Protection Regulations, we are not permitted to charge a fee for collating, copying and reviewing your records. However, we can charge for medical reports requested by an Insurance Company or other commercial organisation and, in some cases, a solicitor.

For your own protection, we recommend strongly that you do not supply your own copy of your medical records to a 3rd party and instead, you give them consent and ask that they obtain them independently.

Collection/Postage

Please note that due to the cost of posting a large quantity of paper, we will supply your records on a USB data stick which will be password encoded. If the file is small enough then we may be able to supply the data via email.

☐ Post my Electronic Records on a data stick.
☐ If possible email my data to.....

Please note that we will post your records only to the address that we hold on file, or to a legal representative (eg solicitor)

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Section 2: Declaration

☐ I am the patient and attach colour copies of 2 forms of Identification.

- *Acceptable forms of ID are: Photo Driving License, Passport, Birth Certificate, Utility Bill (not mobile phone), Credit card or Bank statement, Military/Police/Civil Service ID Card (**Sign at 2,1**)*

☐ I am the patient's legal representative and have been asked to act by the patient under a Subject Access Request; I have verified that my client is the afore named patient and attach their written authority to do so, endorsed with my practice stamp. *(**Sign at 2,2**)*

☐ I am the parent/guardian of the patient, who is under 12 years of age. *(**Sign at 2,3**)*

☐ I am the parent/legal guardian of the patient, who is aged 12 to 16 years of age and who lacks the mental capacity to understand their own care. *(**Sign at 2,3**)*

☐ I have been appointed by the Court to manage the affairs of the patient and enclose a copy of my Power of Attorney/Guardianship Order*(**Sign at 2,1**)*

☐ I am the executor of the will of a patient who is deceased. *(**Sign at 2,3**)*

Please note: If applying under a Power of Attorney, we must hold a copy of the Power of Attorney and that Power must be invoked before we can comply with an access request.

2.1 Applications by the Patient

Patient's Signature: _____

Date: _____

2.2 Applications by legal representatives of the Patient (eg solicitor)

Legal Representative's Signature: _____

Date: _____

Name & Address of Company _____

_____

_____

Stamp for Legal/Professionals

2.3 Applications by non-legal/professional representatives (eg, Parent/Guardian of child u12 /Executor of will etc)

Full Name _____

Applicant's Address _____

_____

Applicant's Relationship to Patient_____

Applicant's Signature _____ Date: _____

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Section 3: Witness (For use by the Practice only)

To be completed by the person confirming the applicant's identity

- I have checked the ID documents/PoA provided by the applicant, or they are known to me,
- The proof of address matches the records held by the practice.
- I know the patient personally

Staff Name: _____

Signature: _____

Date: _____

Practice Stamp

Section 4: Completion

Written to Data Stick By _____ Date _____

Checked By _____ Date _____

Authorised By _____ Date _____

Posted By _____ Date _____

(Note Tracking Number.....)

Only if Collected in person:

Collected by Patient on_____(Date)

Patient's Signature_____ (Ensure matches signature in Section 2)

Staff Signature _____

(Print & sign name)