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.

Section 1: Patient details

Surname		**Maiden name**	
Forename		**Title (i.e. Mr, Mrs, Ms, Dr)**	
Date of birth		**Address:**	
Telephone number		**Postcode:**	
NHS number (if known)		**Email address:**	

Section 2: Record requested

The more specific you can be, the easier it is for us to quickly provide you with the records requested.
Record in respect of treatment for: (e.g. leg injury following a car accident)

Please provide me with online access to my medical records *(preferred method)*	
Please provide me with a copy of records between the dates specified:	
Please provide me with a copy of records relating to the incident specified:	
Please provide me with a copy of records relating to the condition specified:	
Please provide me with a copy of all records held	

Section 3: 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		**Postcode**	

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
- ☐ I have full parental responsibility for the patient and the patient is under the age of 18 and:
  (a) has consented to my making this request, or
  (b) is incapable of understanding the request (delete as appropriate)
- ☐ 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 acting *in loco parentis* and the patient is incapable of understanding the request
- ☐ 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 4: Proof of identity

Please indicate how proof of ID has been confirmed. Please select 'A' or 'B':

	Method in which identity is confirmed	**Option taken**	**Documents attached**
A	Attached copies of documents as noted in section 4A below	Yes/No	If Yes, please indicate here which documents have been attached
B	Countersignature (section 4B). This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided)	Yes/No	Please indicate reason why this section was completed

Section 4A – Evidence

Evidence of the patient's and/or the patient's representative 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 birth certificate, passport, 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 the representative'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 to the 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)

Section 4B – Countersignature

This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section may be completed if 4A cannot be fulfilled.

I (insert full name).....

Certify that the applicant (insert name).....

Has been known to me personally as ..... for .....years
(Insert in what capacity, e.g. employee, client, patient, relative etc.)

and that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed .....Date .....

Name ..... Profession. .....

Address .....

.....

Daytime telephone number .....

CONSENT FOR ONLINE ACCESS TO MEDICAL RECORDS

The following form will take you through the things you need to think about. By signing the form you will be giving us your permission to go ahead with setting up the service for you. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

Declaration (please delete response as appropriate):

1. I agree to my GP practice giving me access to my record online.	YES / NO
2. I have read and understood the information leaflet about access to GP medical records.	YES / NO
3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.	YES / NO
4. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.	YES / NO
5. I agree that it is my responsibility to keep my username and passwords secure. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.	YES / NO
6. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.	YES / NO
7. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.*	YES / NO

Other considerations

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.	
8. If I notice any inaccuracies with my record, I will inform the practice manager as soon as possible of any errors or omissions.	YES/NO
9. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.	YES / NO
10. I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.	YES / NO

Signature of patient……..……..….

Date……

<u>Please retain a copy of this form for your information.</u>

Please remember to keep all your account details secure. If you think your account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service please speak to our practice manager.