**APPLICATION FORM FOR ACCESS TO HEALTH RECORDS**

**in accordance with the General Data Protection Regulation (GDPR)**

**DATA SUBJECT ACCESS REQUEST**

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title**  **(i.e Mr, Mrs, Dr)** |  | **Forename** |  |
| **Surname** |  | |  | | --- | | **Date of Birth** | |  | |  |
| **Address** |  | **Post Code** |  |
| **Telephone number** |  | **NHS Number (if known)** |  |

**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 a copy of all records held from birth** |  |
| **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 below:** |  |
| **Please provide me with a copy of records relating to the condition specified below:** |  |

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

**Section 3: Type of copy**

How would you like to receive your copy, please tick option: **n.b. you will have to collect it from the surgery**

|  |  |  |  |
| --- | --- | --- | --- |
| **View as Patient On Line** |  | **USB Pen** |  |
| **Secure Email attachment** |  | **Disc** |  |
| **View in practice** |  | **Paper** |  |

**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 | Patients Documents photo ID  Utility bill | Yes/No  Yes/No |  |
| B | Countersignature/Vouching. This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided) |  | Please indicate why- |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form for Doctor Reviewing copies of Patient Record

Name of Patient………………………………………………………….

Date Of Birth ……../……/…….

Records Requested By………………………………………………….

I have reviewed the records of this patient and have removed any records which in my opinion would:

* disclose any information likely to cause serious harm to the physical or mental health of the patient or any other individual
* disclose information relating to or providedby an individual other than the patient who could be identified by that information (except where the other individual is a health professional involved with the care of the patient, or unless consent has been given the the other individual).

Signed……………………………………………..