

**Application for Access to Health Records**

**under the Data Protection Act 1998**

**APPLYING FOR THIRD PARTY ACCESS TO MEDICAL RECORDS**

**SECTION 1:** Details of the Medical Record to be accessed:

|  |  |
| --- | --- |
| Patient’s full name: |  |
| Date of Birth: |  |
| Address: |  |
| Contact Telephone Number: |  |

**SECTION 2:** Details of the Person who wishes to access the records, if different to above:

|  |  |
| --- | --- |
| Full Name: |  |
| Address: |  |
| Telephone Number: |  |
| Relationship to Patient: |  |
| Is this person the Patient’s Carer: | Yes / No |
| If ‘yes’, would you like your names to be added to our Carer’s register? This will ensure our records are up-to-date and enable us to provide you with relevant information and advice.  Yes / No | |

|  |
| --- |
| **THIRD PARTY TO ACT ON MY BEHALF** |
| **□** I would like to allow the person named in **section 2** to act on my behalf e.g. Request results of tests, speak to the doctor on my behalf, etc. – *this is often a family member/carer*.  The **patient named in section 1** must sign overleaf and in doing so, is consenting to this request.  *(This consent form will be scanned onto your medical records and will allow the person named in section 2 access to your medical information when requested. You can withdraw this consent at any time by contacting the practice).*  Please detail below if this access is to be limited in any way (e.g. only for test results, or only for making and cancelling appointments, etc.)   |  | | --- | | *Limited access for:* |   Please allow access: Indefinitely □  For a limited period only □  Please specify when this authority is valid until ……………………………………………….. |

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*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 Data Protection Act 1998.*

**If a patient has ‘Lack of Mental Capacity’ and is unable to consent to this request, we would need a copy of a ‘Health and Welfare Lasting Power of Attorney’ evidencing your entitlement to access this information.**

**All patients must consent by signing here. This signature needs to be witnessed by a member of the reception team or a clinician.**

**Patient’s Signature: …………………..……………………………….**

**Date of Application: ………………….…………………………………**

**Please also provide a form of photo ID (e.g. passport, driving license, bus pass etc) to enable us to grant access to your medical record**

**To be completed by Appletree Staff:**

Photo ID checked:

□ Passport

□ Driving License

□ Other, please specify …………………………………………………

Signature Witnessed by member of Appletree □

Staff Member’s Name: ………………………………………………….

Date: ………………………………………………….

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