

DATA SUBJECT ACCESS REQUEST



APPLICATION FORM FOR ACCESS TO HEALTH RECORDS in accordance with the General Data Protection Regulation (GDPR)

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

Requests for medical records for a child

PLEASE NOTE: JENNER HOUSE SURGERY WILL CONSIDER REQUESTS FOR CHILDREN AGED 14-18 YEARS ON A CASE BY CASE BASIS. THE CHILD MAY BE CONTACTED DIRECTLY FOR THEIR CONSENT AND ASKED TO COLLECT THE MEDICAL RECORD THEMSELVES.

Section 1: Patient details

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

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	
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:	

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.



I wish to access my medical record and understand and agree with each of the following statements (please tick):

I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	

Things to consider

Before you apply for access to your record, there are some other things to consider.

Forgotten history

There may be something you have forgotten about in your record that you might find upsetting.

Abnormal results or bad news

You may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

Choosing to share your information with someone

It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

Coercion

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not access your records at this time.

Misunderstood information

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

Information about someone else

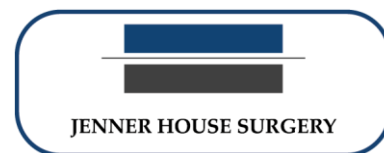
If you spot something in the record that is not about you or notice any other errors, please contact the practice as soon as possible.

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
- NB: JENNER HOUSE SURGERY WILL CONSIDER REQUESTS FOR CHILDREN AGED 14-18 ON A CASE BY CASE BASIS. THE CHILD MAY BE CONTACTED DIRECTLY FOR THEIR CONSENT AND ASKED TO COLLECT THE MEDICAL RECORD THEMSELVES.**

and:

- has consented to my making this request, or 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:

Print Name:

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

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	Copy of birth certificate of child & copy of



	applying on behalf of a child	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)

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 should be completed if 4A cannot be fulfilled.

I (insert full name).....

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

Has been known to me personally as foryears
(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

Additional notes
 Before returning this form, please ensure that you have:

- a) signed and dated this form
- b) enclosed proof of your identity or alternatively confirmed your identity by a countersignature
- c) 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.

For office use only:

Date received:

Deadline:

Date given to GP:

GP Signature:

I confirm I have reviewed the records for the above patient and advise these can now be passed to the patient for collection

Signed:

Print:

Date:

AT POINT OF COLLECTION - Patient receipt of records

I confirm I have received a copy of my medical record as per this subject access request

Name:

Signature:

Date collected: