Bloomfield Medical Centre
Access to Records Request Form

By completing this form you are making a Subject Access Request under the General Data Protection Regulations (GDPR) for information held about you by the practice.
Personal information collected from you by this form is required to enable us to process your request. This personal information will only be used in connection with the processing of this Subject Access Request. This request will be attached to your secure medical record and the paper copy destoryed.
In accordance with legislation no fee will be charged for your request unless it is manifestly unfounded or excessive, particularly if it is repetitive. We will contact you with details of our reasonable administrative charges before any further action is taken.

PLEASE COMPLETE CLEARLY IN BLOCK CAPITALS – we cannot process illegible or unclear forms	
1.	**Details of patient whose records are to be accessed (complete one form per person)**
Surname:	Date of birth:
First Name:	Address:
E-mail:	
Mobile:	Home phone:

2.	**Details of records to be accessed - tick all that apply and give detail requested**		
	Vaccination history		
	Current medications (if no access to Patient Access)		
	Other information		
	From (date)	**To (date)**	**About (condition/event)**
✓	01/02/2017	31/03/2018	All records (EXAMPLE 1)
✓	05/10/1995	Today	Leg injury (EXAMPLE 2)
3.	**Details of applicant if different to the patient**		

Full name: *proof of identity will be required before records can be released	
Company (if applicable):	
Right to information (tick one)	
[ ] Patient authorisation	[ ] Parent/guardian
[ ] Guardianship order (attach copy)	[ ] Lasting power of attorney (attach copy)
[ ] Deceased patient's personal representative (attach confirmation of appointment)	[ ] Claimant arising from patient's death (attach covering letter with further details)
[ ] Other – give details and attach documentary evidence	
e-mail address:	
Mobile phone:	Other contact number:

4.	**Authorisation**

I (Print name) _____ hereby wish and authorise Bloomfield Medical Centre to release the information indicated in section 2 to the above applicant whom I authorise to act on my behalf.

Signature of patient: _____ Date: _____

5.	**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.

I wish to receive the information by *email/*collection from Bloomfield Medical Centre (*delete one)

Signed (Patient/Applicant):_____ Date: _____

Please return this completed form to bloomfield.medical@nhs.net