PARKSIDE GROUP PRACTICE
APPLICATION FOR ACCESS TO MEDICAL RECORDS
General Data Protection Regulations Subject Access Request

Details of the Record to be Accessed:

Patient Surname	NHS Number
Forename(s)	Address
Date of Birth	
Telephone No	
Email	

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

Surname	
Forename(s)	
Address	
Telephone Number	
Relationship to Patient	

Delete as appropriate;

Requests made to access the records of living persons

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 General Data Protection Regulations.

Requests made to access the records of deceased persons

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 Access to Health Records Act.

Tick whichever of the following statements apply.

- ○ I am the patient.
- ○ I have been asked to act by the patient and attach the patient's written authorisation.
- ○ I am acting in Loco Parentis and the patient is under age sixteen, and is incapable of understanding the request / has consented to me making this request. (*delete as appropriate).
- ○ I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that (please supply your reasons below).

Applicant signature................……………………..........Date………………………..

Details of Application
Patient to complete (please tick as appropriate)

I am applying for access to view my records only	
I am applying for copies of my medical record	
I have instructed someone else to apply on my behalf	

Notes:
Under the General Data Protection Regulations you do not have to give a reason for applying for access to your health records.
Under the Access to Health Records Act you will/will not need to give reasons for applying for access to a deceased person's health records.
You may be asked to provide photographic identification.

Please use this space below to inform us of certain periods and parts of your health record you may require, or provide more information as requested above.

This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports.

I would like a copy of records between specific dates only (please give date range) below	
I would like copy records relating to a specific condition / specific incident only (please detail below)	
I would like a copy of all records *(N.B these can only be collected from the practice)*	

The Practice has 28 days to comply with your request. On completion we can make the records available for collection or we can release these via email.

Applicant signature................………………….......................................
(I consent to having my medical records emailed to me)

Applicant signature................………………….......................................
(I consent to collect my medical records from the Practice)

For Practice use only

Name of verifier:	Signature of verifier:	Photo ID seen: ☐	Date:
Name of authorising doctor:	Signature of authorising doctor:		Date: