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

**DATA SUBJECT ACCESS REQUEST**

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

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** | Enter Last Name | **Maiden name** | Enter Maiden Name |
| **First Name** | Enter First Name | |  | | --- | | **Title** | | **(i.e. Mr, Mrs, Ms, Dr)** | | Enter Title |
| **Date of birth** | Enter Date | **Address:**  Enter Address | |
| **Telephone number** | Enter Telephone |
| **Email Address** | Enter Email Address | | |
| **NHS number  (if known)** | Enter NHS Number (If Known) | |  |

**Section 2: Record requested (please complete one of the boxes below)**

|  |
| --- |
| **Please provide me with a copy of records between the dates specified below:**  Click here to enter text. |
| **Please provide me with a copy of records relating to the incident specified below:**  Click here to enter text. |
| **Please provide me with a copy of records relating to the condition specified below:**  Click here to enter text. |
| **Please provide me with a copy of records of all electronic records held:**  Click here to enter text. |

**Section 3: Sending options**

Please state whether you consent to us sending your record by email or whether you prefer to collect the copies yourself.

I consent to Marple Cottage Surgery emailing my medical record to me at the email address specified above.

**Or**

I wish to collect the copies of my medical record from Marple Cottage Surgery.

**Section 4: Details and declaration of applicant**

Please enter details of applicant if different from Section 1

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname** | Enter Surname | | **Title**  **(Mr, Mrs, Ms, Dr)** | Enter Title |
| **Forename(s)** | Enter Forename | | **Address**  Enter Address | |
| **Telephone number** | Enter Telephone | |
| **Capacity in which requesting  (Name of Organisation)** | | Enter Capacity (or Organisation Name) | | |

**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.

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  and:   1. has consented to my making this request, or 2. 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: | **Click here to type signature** | Date: | Enter Date |

**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 5: Proof of identity and evidence**

**Evidence of the patient’s 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 passport or 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  applying on behalf of a child | Copy of birth certificate of child & copy of 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) |

**Additional notes**

Before returning this form, please ensure that you have:

1. Signed and dated this form
2. enclosed proof of your identity
3. 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.