**APPLICATION FORM FOR ACCESS TO HEALTH RECORDS**

**in accordance with the General Data Protection Regulation (GDPR)**

**3rd PARTY 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**

|  |  |  |  |
| --- | --- | --- | --- |
| Title  (i.e Mr, Mrs, Dr) |  | Forename |  |
| Surname |  | |  | | --- | | Date of Birth | |  | |  |
| Address |  | Post Code |  |
| Telephone number |  | NHS Number (if known) |  |

**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 from birth |  |
| Please provide me with a copy of records between the dates specified: |  |
| 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: What format do you need this in: n.b. you will have to collect it from surgery**

|  |  |  |  |
| --- | --- | --- | --- |
| View as patient on-line |  | USB pen |  |
| Disc |  | Secure email attachment |  |
| Paper |  |  |  |

**Section 4: If you are not the patient**

**Please enter details of applicant if different from Section 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Title  (Mr, Mrs, Ms, Dr) |  |
| Forename(s) |  | Address |  |
| Telephone number |  | Postcode |  |
| Relationship to patient |  |  |  |

**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 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

Signature of applicant: ...................................................... 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**

**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 | Patients Documents photo ID  Utility bill  Birth certificate | Yes/No  Yes/No  Yes/No |  |
| B | Representatives Documents photo ID  Utility bill  Power of Attorney | Yes/No  Yes/No  Yes/No |  |
| C | Countersignature/Vouching. This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided) |  | Please indicate why- |

**6 – Countersignature**

**This section is to be completed by someone (other than a member of your family) who**

**can vouch for your identity. This section may be completed if 4A cannot be fulfilled.**

I (insert full name).................................................................................................................

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

Has been known to me personally as .......................................... for ..........................years

(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 .................................................................................................

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Form for Doctor Reviewing copies of Patient Record

Name of Patient………………………………………………………….

Date Of Birth ……../……/…….

Records Requested By………………………………………………….

I have reviewed the records of this patient and have removed any records which in my opinion would:

* disclose any information likely to cause serious harm to the physical or mental health of the patient or any other individual
* disclose information relating to or providedby an individual other than the patient who could be identified by that information (except where the other individual is a health professional involved with the care of the patient, or unless consent has been given the the other individual).

Signed……………………………………………..