**APPLICATION FOR ACCESS TO MEDICAL RECORDS**

**General Data Protection Regulations 2016 Data Subject Access Request**

**Details of the record to be accessed:**

|  |  |
| --- | --- |
| Patient Surname  | NHS Number   |
| Patient Forename(s)   | Address    |
| Date of Birth  |

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

|  |  |
| --- | --- |
| Surname  |   |
| Forename(s)  |   |
| Address    |     |
| Telephone Number  |   |
| 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 General Data Protection Regulations 2016.

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 am the deceased patient’s Personal Representative and **attach confirmation of my appointment.**

* 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).

**NAME……………………….………………………….SIGNATURE……………………..….…………………..DATE………………………..**

 **PATIENT TO COMPLETE: Details of my Application** (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 2016 you do not have to give a reason for applying for access to your health records; however, any specific information you can provide may help us to process your request more quickly and efficiently.

**Optional** - 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. Note: defining the specific records you need may result in a quicker response time.

|  |  |
| --- | --- |
| **I would like a copy of all records:**   |   |
| **I would like a copy of records between specific dates only (please give date range):**     |   |
| **I would like copy records relating to a specific condition / specific incident only (please detail below):**  |   |

**To be completed on collection by individual requesting access:**

I confirm receipt of the following records.

*E.g. All records dated between 2016-2017*

**I understand by taking ownership of these records, I am responsible for their safe keeping, controlled distribution and secure disposal.**

**SIGNATURE……………………..….………………….. DATE………………………..**