APPLICATION FOR ACCESS TO MEDICAL RECORDS

Data Protection Act 1998 Subject Access Request

**Details of the Record to be Accessed:**

|  |  |
| --- | --- |
| Patient Surname | Forename |
| Mobile/tel number | 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 Data Protection Act 1998.

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 the patients carer, or parent 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).

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

There is no longer a charge for copy of records under GDPR unless deemed excessive, or repetitive (within 12 months) in which case you will be notified of a charge in advance.

Continued>>

**Details of my Application** (please tick as appropriate)

**Patient to complete**

|  |  |
| --- | --- |
| **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 Data Protection Act 1998 you do not have to give a reason for applying for access to your health records.

**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.

|  |  |
| --- | --- |
| **I would like a copy of all records** |  |
| **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 an electronic copy of records to be sent via email and text , coded for me to share or use for my own purposes.** |  |
| **I would like my copies in electronic, encrypted format** |  |
| **I would like paper copies (these take up to 30 days)** |  |

# Please note it is your responsibility to keep your copied records safely and securely once released to you. Forms can be sent via email to

# ssicb-nst.kmp@nhs.net

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