**Quarryfoot Practice**

**Access to Health Records & Requests for other personal information**

**GDPR 2018, for living patients**

**ACCESS TO HEALTH RECORDS ACT 1990, for access to deceased patients records**

**Section 1 - Details of person whose records are being requested.**

Surname................................................................................................................................

Former Surname if applicable................................................................................................

First Name (s)........................................................................................................................

Date of Birth...........................................................................................................................

Registered Address...............................................................................................................

Current Address if different from above.................................................................................

...............................................................................................................................................

Postcode................................................................................................................................

Daytime telephone number....................................................................................................

I received the leaflet “How to request GP Records & Other personal information”

**Section 2 – What information is required?**

A DWP/PIP information summary report only

A paper copy of the full record

To view your health records

A paper copy of records for date range

From.......................................to......................................

Other (please specify below)

**Section 5 - Declaration –**

I declare that the information given by me in sections 1-4 is correct to the best of my knowledge and that I am entitled to apply for this information.

Please tick appropriate box:

I am the patient

I have been appointed by the court to manage the affairs of the patient and attach relevant documentation

I am acting on behalf of the patient and the patient has completed the authorisation (section 6)

I am the deceased patient’s representative and attach confirmation of my status

I have Welfare Power of Attorney for this patient and attach relevant documentation

Other, specify................................................................................................................

Patient or Applicant’s name …………………………………………………………….........……

Patient or Applicant’s signature..............................................................................................

Address if different from above……………………………………............................................

Daytime telephone number......................……………………………………………........……..

**Please ignore this section if you are requesting your own health records/personal information**

**Section 6 - Patient’s Authorisation**

I authorise Quarryfoot Practice to release the information requested

to............................................................................................................................................

I have given consent for them to act on my behalf.

Signature

…………………………………............……………Date...…………………………….

Please return this form to Quarryfoot Practice, Bonnyrigg Health Centre, 109-111 High Street, Bonnyrigg EH19 2ET.

Remember that you will need to have your ID verified at the Practice.

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**Confirmation of identity (OFFICE USE ONLY)**

**ID checked/Patient verified**

**Patient verified by............................. Date...........................................**