APPLICATION FOR ACCESS TO MEDICAL RECORDS

**General Data Protection Regulations (GDPR) Subject Access Request (SAR)**

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

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

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

|  |  |
| --- | --- |
| Surname: | Address: |
| Forename(s): |
| 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 GDPR.

## Access to personal information / Subject Access Requests

You have a right under the General Data Protection Regulations 2018 to request access to view or to obtain copies of what information the surgery holds about you and to have it amended should it be inaccurate. In order to request this, you need to do the following:

* Your request must be made in writing to the GP, this can be made by email or letter (note for information from the hospital you should write direct to them)
* We will initially offer you online access to your Detailed Coded Record. This contains your electronic medical record, and summarised paper record. It does not contain any letters from the hospitals or other attachments on your record. The advantage of applying for access to this record is that it updates as your medical record updates, so you will always have the most current information.
* If the Detailed Coded Record is not adequate for your needs, we will email you a copy of your medical record. If you are not able to receive an email containing your medical record, you will print a copy for you. There may be a charge to have a printed copy of the information held about you if the administrative burden of photocopying and printing is excessive.
* We are required to respond to you within 1 calendar month.
* You will need to give adequate information (for example full name, address, date of birth, NHS number and details of your request) so that your identity can be verified and your records located

Tick whichever of the following statements apply.

* I am the patient **(Proof of identity will need to be seen).**
* I have been asked to act by the patient and attach the patient’s written authorisation **(A copy of this will need to be kept on our records).**
* 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 **(A copy of this will need to be kept on our records**
* 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 in writing).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Your Name** |  | **Your Signature** |  | **Date** |  |

**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 GDPR you do not have to give a reason for applying for access to your health records.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Name** |  | **Patient Signature** |  | **Date** |  |

**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.

|  |  |
| --- | --- |
| **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)** |  |

**PLEASE NOTE:** You should be aware that once the information you request has left the practice at your instruction, The Clays Practice are no longer the Data Controller for that information and that we have no control over who sees the records, how that information may be used and by whom. Therefore you should consider whether you want to request your whole medical records and history or whether you wish to release only a specified period of time or relevant dates for the matter being dealt with.

|  |  |
| --- | --- |
| For Practice Use only | |
| Name of person receiving this document |  |
| Date Document received |  |
| What Patient identification (Passport, drivers licence, birth certificate, etc.) has been witnessed? |  |
| And/or | |
| How was the relationship to the patient verified (POA, written consent, etc. - a copy of this document must be scanned) |  |