*The General Data Protection Regulation (GDPR) gives people the right to know what personal information an organisation has about them. To use this right, you can make what is known as a ‘subject access request’.*

*Only the following people may apply for access to personal information.*

* *The person who the information is about.*
* *Someone acting on behalf of the person who the information is about.*

*You have a right to know whether or not we have any information about you, and a right to have a copy of that information. You have a right to know the following.*

* *What kind of information we keep about you.*
* *The reason we are keeping it and how we use it.*
* *Who gave us your information*
* *Who we might share your information with and who might see your information.*

*You also have the right to have any codes or jargon in the information explained.*

*You won’t be able to see information that could:*

* *cause serious harm to your physical or mental health, or anyone else’s*
* *identify another person (except members of NHS clinical staff who have treated the patient), unless that person gives their permission.*

*If you need any more advice about your rights under the General Data Protection Regulation, please contact our Data Protection Officer or, you can contact the Information Commissioner’s Office:*

|  |  |
| --- | --- |
| *Data Protection OfficerHermitage Medical Practices**5 Hermitage Terrace**Edinburgh**EH10 4RP**0131 447 6277* | *The Information Commissioner’s Office – Scotland**45 Melville Street**Edinburgh**EH3 7JL.**Phone: 0131 244 9001**Email: Scotland@ico.org.uk* |

*If you want to make a subject access request, please fill in the form attached.*

***Fee***

*Data will be provided* ***free of charge****. There may be a charge of a ‘reasonable fee’ when a request is manifestly unfounded or excessive, particularly if it is repetitive.*

*A reasonable fee may occur when complying with requests for further copies of the same information. This does not mean that there will be a charge for all subsequent access requests.*

*The fee must be based on the administrative cost of providing the information.*

***Response time***

*We will deal with your request as quickly as possible and within 30 days of receiving your request. If we have any problems getting your information we will keep you up to date on our progress.*

***How long records are kept***

*The usual rules to do with keeping records are that:*

* adult general hospital records are kept for six years after the date of the last entry;
* *maternity records are kept for 25 years after the birth of the last child;*
* *children’s and young people’s records are kept until the child’s or young person’s 25th birthday; and*
* *mental-health records are kept for 20 years after the date of the last contact.*

***Points to consider***

*Making false or misleading statements to access personal information which you are not entitled to is a criminal offence.*

*Accessing health records and information is an important matter. Releasing information may in certain circumstances cause distress. You may want to speak to an appropriate health professional before filling in the form.*

*We ask for proof of ID because we have confidential information and we must get proof of your identity and your right to receive any relevant information.*

***Notes to help you fill in the form***

***Personal information***

*Personal information is information we hold about people in medical records, patient administration and information systems, clinical systems, and other databases or files. We may hold personal information on paper or on computer.*

***Health professionals***

*An appropriate health professional may include your hospital doctor, nurse, midwife or health visitor, dentist, optician, pharmacist, clinical psychologist, occupational therapist, dietician, physiotherapist, podiatrist or speech and language therapist.*

***Section 1: Personal details***

*This is the person to whom the data relates. Please ensure that this section is completed as fully and accurately as possible to enable us to trace all the required information.*

***Section 2: Information you want to access***

*The General Data Protection Regulation covers both manual (paper) and computerised records. Manual records include all your paper health records. Some information about your care may also be held on computer.*

*If you wish to view the original record you will be invited to attend the Practice at a convenient time. If you wish to receive photocopies these will be produced within 30 days.*

***Section 4: Identification/Declaration***

*Everyone must complete this section UNLESS you are providing:*

* *A certified copy of a Power of Attorney document*
* *A certified copy of a Guardianship Order*

*Because of the confidential nature of the information held by the organisation, it is essential for us to obtain proof of your identity and your right to receive any relevant information.*

|  |  |
| --- | --- |
| ***Send your filled-in form to:*** | ***Carol Stewart******Hermitage Medical Practices******5 Hermitage Terrace******Edinburgh******EH10 4RP*** |

|  |  |
| --- | --- |
| ***Who to contact in the organisation if you have any complaints:*** | ***Patient Experience Team******NHS Lothian******Waverley Gate******2-4 Waterloo Place******Edinburgh******EH1 3EG*** |

**Subject Access Request for Copies of Personal Medical Record**

|  |
| --- |
| Section 1 – Your Details |
| Please make sure you use your formal name in this section |
| GP you usually see |  |
| First Name |  | Other Initials |  |
| Surname |  |
| Address  |  |
|  |  |
| Post Code |  |
| Date of Birth |  |
| Telephone Number |  |
| Processing your request may take up to 30 days. We will contact you on the above number to let you know when the records are ready to collect. Are you happy for us to leave a message at this number?  | Yes | No |
|  |  |
| Records should normally be collected from the practice in person. If you would like someone else to collect the copy of your medical record, enter their name here (please tell them they will need to bring a form of photo ID with them when they collect your record):I give you, **Hermitage Medical Practice**, permission to give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Collector Name/the person acting on your behalf) the personal information requested in this form. I have given them permission to act on my behalf. Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Section 2 – Information you require – please complete 1,2, 3, 4 or 5. |
| 1. | Please provide me with my immunisation record only | Tick |  |
| 2. | Please provide me with copies of my medical records for the following period |
| From: |  | To: |  |
| 3. | Please provide me with a print-out of my medical records from 2005 onwards (these are held on computer) | Tick |  |
| 4. | Please provide me with copies of my entire medical records from my date of birth to date | Tick |  |
| 5. | Make appointment to view original records only | Tick |  |
| Section 4 – Signature |
| Signed |  | Date |  |
| **Please hand this form to the receptionist along with 2 forms of ID (one of which should be photo ID eg. passport or photo driving licence plus utility bill or council tax bill)** |
|  |
| For Practice Use ONLY |
| Action | Signed | Date |
| **Identity verified** |  |  |
| **Please list documents seen** | 1. | 2. |
| **Data Extracted** |  |  |
| **Data Checked**  |  |  |
| Patient advised ready to collect |  |  |
| Notes |  |

SUBJECT ACCESS REQUEST

**[Please sign this form to confirm receipt of the information you requested in your recent subject access request.]**

I confirm that I have received a copy of my confidential records under the General Data Protection Regulation (2016). I am fully aware that, once in my possession, it is my responsibility to ensure the confidentiality of these documents.

Signature………………………………………………………………

Date……………………

[FOR OFFICE USE ONLY]

HANDED OVER BY. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

IDENTIFICATION CHECKED. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

*(if collected by someone other than patient)*