APPLICATION FORM FOR ACCESS TO HEALTH RECORDS
in accordance with the General Data Protection Regulation (GDPR)
DATA SUBJECT ACCESS REQUEST

This form must be completed in blue or black ink and signed in order for us to process your request.
Please note records will be emailed to the requestor.
If you require paper copies please state on the form where you will then be contacted when they are ready to collect from the Practice.

Section 1: Patient Details

Surname		**Maiden Name**	
Forename		**Title (i.e. Mr,Mrs,Ms,Dr)**	
Date of Birth		**Address:**	
Telephone Number		**Postcode:**	
NHS Number (if Known)		**Hospital Number (If known)**	
Email Address			

Section 2: Record Requested

The more specific you can be, the easier it is for us to provide you with the records.
PLEASE NOTE WE REQUIRE 28 DAYS NOTICE FOR THESE REQUESTS.
Record in respect of treatment for: (e.g. leg injury following a car accident)

Please provide me with a copy of records between the dates specified below:	**The Reason for this request :-**
Please provide me with a copy of records relating to the incident specified below :	**The Reason for this request :-**
Please provide me with a copy of records relating to the condition specified below:	**The Reason for this request :-**

IMPORTANT INFORMATION

FULL MEDICAL RECORDS WILL NOT BE PROVIDED FOR BENEFIT CLAIMS i.e. Universal Credits/PIPS/ Disability. THE PRACTICE CAN REFER YOU TO THE SOCIAL PRESCRIBING TEAM WHO CAN ASSIST YOU WITH YOUR BENEFIT CLAIMS IF YOU WISH. PLEASE SPEAK TO RECEPTION. Thank you

IN RESPECT TO REQUESTS FROM SOLICITORS FOR COPIES OF FULL MEDICAL RECORDS THIS REQUEST MUST BE PLACED IN WRITING BY THE SOLICITOR TO THE PRACTICE ADDRESSED AS FOLLOWS:

The Medical Secretaries

Lionwood Medical Practice 30a Wellesley Avenue North Norwich NR1 4NU

Section 3: Details and Declaration Of Applicant

Please enter details of applicant if different from Section 1

Surname		**Title (Mr,Mrs,Ms,Dr)**	
Forename(s)		**Address**	
Telephone Number		**Postcode**	

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.

Please tick:

☐ I am the patient

☐ I have been asked to act by the patient and attach the patient's written authorisation I have full parental responsibility for the patient and the patient is under the age of 18 and:
(a) has consented to my making this request, or
(b) is incapable of understanding the request (delete as appropriate)

☐ I have been appointed by the court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so

☐ I am acting in loco parentis and the patient is incapable of understanding the request

☐ I am the deceased person's Personal Representative and attach confirmation of my appointment (Grant of Probate/Letters of Administration)

☐ I have written, and witnessed, consent from the deceased person's Personal Representative and attach Proof of Appointment

☐ I have a claim arising from the person's death (Please state details below)

Signature of applicant: ..... Date: ……..

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Signature of Administrator:..... Date: …….

Signature of GP:..... Date: …….

Section 4: Proof of Identity

Please indicate how proof of ID has been confirmed. Please select 'A' or 'B':

	Method In Which Identity Is Confirmed	Option Taken	Documents Attached
A	Attached Copies of Documents As Noted In Section 4A below	Yes / No	If Yes please indicate here which documents have been attached
B	Countersignature (Section 4B) This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided)	Yes/No	Please indicate reason why this section was completed

4A – Evidence

Evidence of the patient's and/or the patient's representative identity will be required. Please attach copies of the required documentation to this application form. Examples of required documentation are:-

	Type of Applicant	Type of Documentation
A	An individual applying for his/her own records	One copy of identity required e.g. Copy of Birth Certificate, Passport, Driving Licence, Plus One Copy of a Utility Bill, Medical Card etc
B	Someone applying on behalf of an individual (Representative)	One item showing proof of the patient's identity and one item showing proof of the representative's identity (See Examples in 'A' above)
C	Person with parental responsibility applying on behalf of a child	Copy of Birth Certificate of child & copy of correspondence addressed to person with parental responsibility relating to the patient
D	Power of Attorney / Agent applying on behalf of an individual	Copy of a court order authorising Power of Attorney/Agent plus proof of the patient's identity (See Example in 'A' above)

4B – Countersignature

This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section may be completed if 4A cannot be fulfilled.

I (insert full name).....

Certify that the applicant (insert name).....

Has been known to me personally as ..... for .....years
(Insert in what capacity, e.g. employee, client, patient, relative etc.)

and that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed .....Date .....

Name ..... Profession. .....

Address .....

.....

Daytime Telephone Number .....

Additional Notes

Before returning this form, please ensure that you have:

a) Signed and Dated This Form

b) Enclosed Proof Of Your Identity or Alternatively Confirmed Your Identity By A Countersignature

c) Enclosed Documentation To Support Your Request (if applying for another person's records)

Incomplete applications will be returned; therefore please ensure you have the correct documentation before returning the form