Annex A

APPLICATION FOR ACCESS TO MEDICAL RECORDS

SUBJECT ACCESS REQUEST & ON LINE ACCESS

Section 1 - Details of the Record to be accessed:

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

If you are applying to view your own records please go to Section 2. If you are applying to view another person's record please go to Section 3.

Section 2 - Details of the Application

To be completed if you are the Patient named above:

I confirm I am the patient named above	☐
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 and have indicated below if there are any limitations to access.	☐

Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)

Patient Signature		**Date**	

Section 3 - Details Of The Person Who Wishes To Access The Records

To be completed if you are requesting access on behalf of the Patient named above:

Surname	
Forename(s)	
Address	
Telephone Number	
Relationship to Patient	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Which of the following statements apply:

I have been asked to act by the patient and they have signed the declaration below	☐
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.	☐
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).	☐

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.

I agree to pay the appropriate fee for the disclosure required.

Applicant Signature		**Date**	

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.	
Signature	
Date	

Section 4 – Records Required

- Under the General Data Protection Regulation 2018 you do not have to give a reason for applying for access to your health records.

- You will be asked to provide photographic identification

- Please use the space below to inform us of certain periods and parts of the 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 access to my records online (please complete section 6)	☐
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 a copy of all records	☐

Section 5 - Consent for children under 16 (Gillick Competence)

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

I am the Patient/Parent/Guardian (delete as necessary)	
Signature	
Full Name	
Address	
Date	

Section 6 - Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐
Authorised by		Date
Date account created		

Date passphrase sent	
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed ☐	Notes / explanation