**Patient Access to Medical Records - Request Form**

**Access to Health Records under the General Data Protection Regulations 2018 (Subject Access Request)**

Patient’s authority consent form for release of health records (Manual or Computerised Health Records)

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| --- |
| To: Gateway Primary Care, Chatham Street, RotherhamS65 1DT  |

**Details of individual for whom the information is requested for**

|  |  |
| --- | --- |
| Full Name | Former name(s) |
| Current address: | Former address (with dates of change) |
| Date of birth: | NHS number: |
| Contact phone number: | E-mail address: (optional) |

**What is being applied for (tick as applicable).**

|  |  |
| --- | --- |
| Arrange an appointment to **view** medical records |  |
| **Copies** of medical records |  |
| **Printed** **summary** of medical records  |  |

You do not have to give a reason for applying for access to your health records. However, to help the Practice save time and resources, it would be helpful if you could provide details below, informing us of periods and elements of the medical records required, along with details which you may feel have relevance i.e. consultant name, location, written diagnosis and reports etc. Please use the space on the following page to document this information:

**Specific details of medical records required:**

|  |
| --- |
|  |

**Please tick the appropriate box:**

|  |  |
| --- | --- |
| **Option 1:** I am applying for my own medical records and will collect myself |  |
| **Option 2:** I am applying for my own medical records but have authorised my representative to collect my medical record on my behalf |  |
| **Option 3:** I am the patients representative and am applying on their behalf for access to medical records under one of the following:* I have been appointed by the Court to manage the patient’s affairs (evidence required - copy of court order)
* I am the deceased person’s personal representative (evidence of appointment required - grant of probate/letters of administration)
 |  |

**Representative details:** (only complete if option 2 or option 3 above has been selected)

|  |
| --- |
| **Representatives full name:** |
| **Representative Current address:** |
| **Representative Date of birth:** | **Representatives NHS number:** |
| **Representative Contact number:** | **Representative E-mail address: (optional)** |

**Signatures:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients Signature:** (Required if Option 1 and 2 ticked above) |  | **Date:** |  |
| **Representatives signature:** (Required if Option 2 or 3 ticked above) |  | **Date:**  |  |

**ADDITIONAL NOTES:**

Before returning this form, please ensure that:

* All the form has been completed and has been signed and dated
* Proof of your identity if available (if this is not possible please speak with reception staff)
* Any relevant documentation is available to support your request i.e. court orders / probate grants (if applicable)

**For office use only:**

|  |  |
| --- | --- |
| **Date Request received:** |  |
| **Comments:** |  |
| **Patient identity verified by:** | **Date:** |
| **Method** | 🞏 Photo ID – Type: Passport / Driving License / Home office Card🞏 Vouching – by whom - staff members only:  |
| **Representative identity verified by:** | **Date:** |
| **Method** | 🞏 Photo ID – Type: Passport / Driving License / Home Office Card🞏 Vouching – by whom – staff members only: |
| **Date request completed:** |  |
| **Signature of patient/representative when collected**  |  | **Date:** |