**Topsham Surgery**

**Application Form for Access to Health Records in Accordance with**

**the General Data Protection Regulations**

**Data Subject Access Request**

**Section 1 : Patient Details**

|  |  |
| --- | --- |
| Surname: | DOB: |
| First Name: | |
| Address: | |
| NHS Number (if known) | |
| Telephone Number: | Mobile Number: |
| Email Address: |  |

**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 Record to be Accessed**

|  |  |
| --- | --- |
| I confirm I am the patient named above | 🞏 |
| I am applying for access to view my records only | 🞏 |
| I am applying for electronic 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 GDPR.

|  |  |  |  |
| --- | --- | --- | --- |
| **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 GDPR you do not have to give a reason for applying for access to your health records.
* You will be asked to provide photographic identification if you wish to have Online Access to your medical records, even if you already have access to appointments, prescriptions etc.
* Please use this 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 an electronic copy of records relating to a specific condition/specific incident only (please detail below) | 🞏 |
| I would like an electronic copy of records between specific dates only (please give date range) below | 🞏 |
| I would like an electronic copy of all records | 🞏 |
| We can provide your records through online access, via secure email or on a disc. Please specify which you would prefer and provide your email address if this is your preferred method. |  |

**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** |  |