

**Data Protection Act – Request for Copies of My Medical Records
NOT TO BE USED FOR REQUESTING A SIGNED DOCTORS LETTER**

Section 1 – Your Details

	Title		Surname	
First Name				
Second Name			Other Initials	
Address				
		Post Code		
Date of Birth				
Home Number		Mobile Number		
Email				

All requests for medical records are free of charge unless you make a duplicate request for the same information. Requests can take up to 30 days to complete (GDPR) . Please tick to indicate you understand this.	Yes <input type="checkbox"/>
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If the telephone number is a mobile phone, would you like us to update your records so that you receive text message appointment reminder and other health messages, communications and reminders from us? (please tick)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Section 2 – Information you require – please select **ONE of the following options. If you select more than one option, your form will NOT be processed.**

1.	Please provide me with a full print-out of my medical records that are held on computer	Tick:	<input type="checkbox"/>
2.	Please provide me with an encrypted CD containing copies of my entire medical records from my date of birth to date (to include any paper records as well as those held on computer, this includes computer records as per Option 1)	Tick:	<input type="checkbox"/>
3.	Please provide me with specific information as described below (Please restrict this to ONE item only such as Blood Tests on a certain date:- -----)	Tick:	<input type="checkbox"/>
4.	Please provide me with a list of my Immunisations/Vaccinations	Tick:	<input type="checkbox"/>

Section 3 – My Health Record Statements – All items MUST be ticked for your form to be processed.

5.	I wish to access My Health Record, and understand and agree with each of the following statements (please tick):	
	a. The Practice may contact me via email, text or phone using the details provided.	<input type="checkbox"/>
	b. I will be responsible for the security of the information that I see, store, print or download.	<input type="checkbox"/>
	c. If I choose to share or disclose my information with or to anyone else, this is at my own risk.	<input type="checkbox"/>
	d. The practice has NO responsibility should someone without my agreement access my data outside of the Medical Centre.	<input type="checkbox"/>
	e. If I see information in my record that is not about me or is inaccurate, I will contact the practice to advise as soon as possible.	<input type="checkbox"/>

Section 4 – Signature

Signed		Date	
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PLEASE NOTE: Future requests for the same information will be chargeable.

**Please hand this form to the receptionist along with a photographic form of ID
(eg passport or photo driving licence)**

**If you do not have photographic ID then two other forms of ID will be needed such as a
utility bill and council tax bill**

For every Subject Access Request application, the following checks **must** be completed by nominated staff
in line with Practice Policy.

For Office Use Only – Please DO NOT complete anything below.

Part A – Application Form Checks and Identity Verification

1. **Application Form checked** to ensure it is **signed, dated and all relevant sections** have been **completed**

2. **Identity Verification**

a. **Patient's identity was verified** by acceptable form

Details of Acceptable Form of ID Viewed:

A valid photo Driving Licence

A valid Passport

A valid CitizenCard

A valid PASS card

Patient's identity was verified by alternative method

Details:-.....

Identity verification completed by (Full Name)	Date:
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Part B – Clinical System Updates & Medical Record Review

3. **Patient's name and date of birth** checked on this form and updated on the clinical system.(if necessary)

4. **Patient's preferred language, communication need and contact details** updated on the clinical system. (if necessary)

5. **Medical Record Review**

Review complete and access provided: Yes / No

If No, please advise details of next course of action:

Medical Record Review and Scanning Approved by (Full Name & Signature)	Date:
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Part C – Application Completion

6. Application and completed checklist passed for Scanning to patient record

PLEASE NOTE: Future requests for the same information will be chargeable.