**REQUEST FOR ACCESS TO MEDICAL RECORDS**

The Data Protection Act gives patients or their representatives a right of access, subject to certain exemptions, to their health records. Haygarth Doctors respects the rights of individuals to have copies of their information wherever possible.

**Personal information collected from you by this form, is required to enable your request to be processed, this personal information will only be used in connection with the processing of this Subject Access Request.**

Charges Payable: In accordance with legislation **no fee** will be charged for your request, unless the request is manifestly unfounded or excessive, particularly if it is repetitive. Before any further action is taken, we will contact you with details of our “reasonable administrative charges” in order to comply with your request.

**PLEASE COMPLETE IN BLOCK CAPITALS – Illegible forms will delay the time taken to respond to requests**

**Details of Patient record to be accessed** (please complete one form per person)

|  |  |
| --- | --- |
| Surname |  |
| Forename(s) |  |
| Address | Postcode |
| Telephone Number |  |
| Date of Birth |  |
| NHS Number |  |

**Details of Applicant** (complete if different to patient details above)

|  |  |
| --- | --- |
| Full Name |  |
| Company (if applicable) |  |
| Address | Postcode |
| Telephone Number |  |
| Relationship to Patient |  |

**Authorisation to release to applicant** (to be completed by the patient if not making their own request)

I (Print name) ………………………………………………….. hereby authorise Haygarth Doctors

to release any personal data they may hold relating to me to the above applicant and whom I authorise to act on my behalf

**Signature of Patient** ……..……………………………………….. **Date** …………………………….

**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 record(s) referred to above under the terms of the Data Protection Act.**

**Please select one box below:**

* I am the patient (data subject)
* I have been asked to act on behalf of the data subject and they have completed the authorization above
* I am acting on behalf of the data subject who is unable to complete the authorization section above (covering letter with further details supplied)
* I am the parent/guardian of a data subject under 16 years old who is unable to understand the request / has consented to my making the request on their behalf (delete as appropriate)

**Please Note:**

* If you are making an application on behalf of somebody else we require evidence of your authority to do so i.e. personal authority, court order etc
* It may be necessary to provide evidence of identity (i.e. Driving Licence)
* If there is any doubt about the applicant’s identity or entitlement, information will not be released until further evidence is provided. You will be informed if this is the case
* Under the terms of the Data Protection Act, requests will be responded to within one month after receiving all necessary information and/or fee required to process the request
* Under the terms of Section 7 of the Data Protection Act, information disclosed under a Subject Access Request may have information removed, this is to ensure that the confidentiality is maintained for third parties referred to who have not consented to

their information being disclosed

**SIGNED (APPLICANT)** …..…………………………..…………………………………………….

**PRINT NAME** ……………………………………………**DATE** …………………………………..

Optional - Please use this space below to inform us of certain periods and parts of your health record you may require. This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports. Defining the specific records you need may result in a quicker response

|  |  |
| --- | --- |
| I would like a report relating to a specific condition/ specific incident only – please provide details  ………………………………………………………………………………………….  …………………………………………………………………………………………. |  |
| I would like a copy of records between specific dates only – please state date range  …………………………………………………………………………. |  |
| I would like a paper copy of my computer held record only  (All medical information [consultations, investigations etc] held electronically since 2005) |  |
| I would like a copy of all records |  |