THE AVENUES MEDICAL CENTRE

APPLICATION FOR ACCESS TO MEDICAL RECORDS

General Data Protection Regulations 2018 Subject Access Request

**Details of the Record to be Accessed:**

|  |  |
| --- | --- |
| Patient Surname: |  |
| Forename(s) |  |
| Date of Birth |  |

**Details of the Person who wishes to access the records, if different to above:**

|  |  |
| --- | --- |
| Surname |  |
| Forename(s) |  |
| Address |  |
| Telephone Number |  |
| Relationship to Patient |  |

Tick whichever of the following statements apply.

* I am the patient.
* I have been asked to act by the patient and attach the patient’s written authorisation.
* 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).

Please use this space below to inform us of any certain periods and parts of your 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.

If copies of all medical records are required please also note this here.

**Notes:**

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

Your request will be actioned within 30 days.

You will not be charged for this request however we can refuse or charge for requests that are manifestly unfounded or excessive.

Photo identification will be required prior to request and receipt of medical records.

**YOUR SIGNATURE……………………..DATE………………………..**

Practice Staff Use only:

ID Seen:

Photo Driving Licence: □

Passport: □

Other: □