**Birchwood Medical Practice**

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

Patient’s authority consent form for release of health records (Manual or Computerised Health Records). Access to Health Records under the General Data Protection Regulations 2016 (Subject Access Request)

Requests for access to medical records will be ready for viewing/collection between **7 – 28 days** from the date the Practice receive your request.

Alternatively, we recommend that patients view their full medical records via the NHS App which is a free service and is a much faster option.

**Identity of individual about whom information is requested**

|  |  |
| --- | --- |
| Full Name | Previous Name(s) |
| Current Address | Date of Birth |
| NHS Number (if known) | Preferred Phone Number |
| Email address |

**What would you like to apply for (tick one):**

|  |  |
| --- | --- |
| I am applying to view my health records(*A 30min appointment will need to be made with a member of our administration team)* |  |
| I am applying for printed copies of my health record*(Printed copies will incur an admin fee of 10p per printed page i.e. a double sided document = 20p)* |  |
| I am applying for copies of my health record to be emailed ***By ticking this box and signing page 3 of this form, you are granting consent for private and confidential medical records to be emailed to the address provided above.***  |  |

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 your health records you require, along with details which you may feel have relevance i.e. consultant name, location, written diagnosis and reports etc.

**Specifications**

|  |
| --- |
|  |

**Please tick the appropriate box identifying whether you or a representative on your behalf is applying for access.**

|  |  |
| --- | --- |
| I am applying to access my health records |  |
| I have instructed my authorised representative to apply on my behalf |  |

**If you are the patient’s representative, please complete this section with you details:**

|  |
| --- |
| Representative’s Name / Company (include address) |
| Contact number and E-mail |
| Relationship to patient  |
| Signature |

**I declare that the information given by me is correct to the best of my knowledge and I am entitled, or have given consent for my representative listed, to apply for access to the health records referred to above.**

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Use Only**

Application Received by (staff): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**For Office Use Only**

GP, please sign to confirm that all records are relevant and appropriate for the patient to view and authorize consent as requested.

I, …………………………………………………………………………. authorise consent to access medical records.

Date………………………………………………………………

