TEMPLEPATRICK SURGERY
APPLICATION FOR ACCESS TO HEALTH RECORDS

Access to Health Records Act 1990/Data Protection Act 1998)

PLEASE COMPLETE IN BLOCK CAPITALS & BLACK INK`

DO YOU REQUIRE PHOTOCOPIES: YES NO (*DELETE AS NECESSARY*)

UNDER GDPR REGULATIONS PLEASE ALLOW UP TO 20 WORKING DAYS FOR YOUR REQUEST TO BE PROCESSED. PLEASE BE AWARE THAT UNDER GDPR ALL THIRD-PARTY INFORMATION WILL BE REMOVED.

PARTICULAR OF PERSON WHOSE INFORMATION IS REQUIRED

Surname:	Forename(s):	Sex:
Current Address:		
Tel No:	Date of Birth:	
If your name and/or address was different from the above during the period(s) to which your application relates, please give details		
Previous Surname:	Previous Address:	

DETAILS OF REQUEST

Please state the exact requirements of your request below.

I would like access/copies of my medical records from …….…… to ……..……..

(*insert dates)*

With particular reference to (for example hospital letters, consultations etc)

……

……

……

……

Signed :……..……..

Print Name:……

Date:……

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DECLARATION

I declare that the information given by myself is correct to the best of my knowledge and that:

(Please tick the box that is appropriate)

- ❖ I am the patient ☐
- ❖ I am acting on behalf of the patient ☐
- ❖ I am the parent or guardian, and the patient is under 16 years of age ☐
- ❖ I am the deceased patient's representative and attach confirmation of this. ☐
- ❖ I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that: ☐

AUTHORISATION **(Where appropriate)**

Part 1 (on behalf of another person)

I authorise Templepatrick Surgery to release information from my Medical Records to :……...

to whom I have given my consent to act on my behalf.

Signature:……

Print Name: Date:…….

Part 2 (in the case of a person under the age 16, a responsible adult should certify, where appropriate that the child understands the nature of the application)

I (name) ……

of (address)……

……

Signature:

Print Name:

CERTIFICATION (to be completed by all applicants)

I certify that I am (name) ……

of (address)……

……

And I have known the applicant for ……..years as an *employee/client/patient/personal friend and have witnessed the applicant sign this form.

Signature:……..

Print Name:

OFFICIAL USE ONLY

APPLICATION RECEIVED (date):…… APPLICATION RECEIVED BY:……

REQUEST TO BE PROCESSED BY (date):……..

ACCESS/COPIES PROVIDED ON (date):……

ACCESS/COPIES PROVIDED BY (name):