BIRCHDALE ROAD MEDICAL CENTRE

2 BIRCHDALE ROAD
LONDON E7 8AR
Tel: 020 8472 1600 Fax: 020 8471 7712

Patient Access to Medical Records/Subject to Access - Information Leaflet

The General Data Protection Regulation (GDPR) gives every living person, or an authorised representative, the right to apply for access to their health records.

A request for your medical health records held at Birchdale Road Medical Centre should be made in writing (e-mails also accepted) to the data controller who is Ms Shila Pindoriya (Practice Manager)

We are not obliged to comply with your access request unless we have sufficient information to identify you and to locate the information held about you. If this is not provided, we may contact you to ask that such evidence be forwarded before we comply with the request. With this in mind we as that you complete a **Subject Access Request form.**

Requests made in relation to your data from a third party should be accompanied by evidence that the third party is able to act on your behalf. If this is not provided, we may contact the third party to ask that such evidence be forwarded before we comply with the request.

Under the GDPR you will not be charged to have copies of your medical records. However, repeat requests and unfounded or excessive requests may be refused or a charge may apply.

Once we have all the required information, and fee where relevant, your request should be fulfilled within one month (*in exceptional circumstances where it is not possible to comply within this period you will be informed of the delay and given a timescale for when your request is likely to be met*).

In some circumstances, we may withhold information held in your health record. These rare cases are:

- Where it has been judged that supplying you with the information is likely to cause serious harm to the physical or mental health or condition of you, or any other person, or;

- Where providing you with access would disclose information relating to or provided by a third person who had not consented to the disclosure, this exemption does not apply where that third person is a clinician involved in your care.

When making your request for access, it would be helpful if you could provide details of the time-periods and aspects of your health record you require (*this is optional, but it may help save practice time and resources and reduce the cost of your access request*).

If you are using an authorised representative, you need to be aware that in doing so they may gain access to **all** health records concerning you, some of which may not all be relevant. If this is a concern,

you should inform your representative of what information you wish them to specifically request when they are applying for access.
If you want your records in to be e-mailed to you please note that we will need your written agreement that you accept the risk of sending un-encrypted information to a non-NHS email address. (Our NHS email address is secure, but private emails are not secure)

If you have any complaints about any aspect of your application to obtain access to your health records, you should first discuss this with the clinician concerned. If this proves unsuccessful, you can make a complaint through the NHS Complaints Procedure by contacting the Practice formally.

Further information about the NHS Complaints Procedure is available on our practice website at: https://www.birchdalemedicalcentre.nhs.uk/

Alternatively you can contact the Information Commissioners Office (responsible for governing GDPR compliance). Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF. Tel: 0303 123 1113 (local rate) or 01625 545 745 if you prefer to use a national rate number or visit **https://ico.org.uk/**

BIRCHDALE ROAD MEDICAL CENTRE

Patient Access to Medical Records - Request Form

Access to Health Records under the GPDR (Subject Access Request)

Patient's authority consent form for release of health records (Manual or Computerised Health Records)

(**please print all details and use dark ink**)

To: Dr M. S. Esmail
Practice Manager: Shila Pindoriya

Birchdale Road Medical Centre
2 Birchdale Road
Forest Gate
London
E7 8AR

Identity of individual about whom information is requested

Full Name	Former name(s)
Current address	Former address (with dates of change)
Date of birth	NHS number (if known)
Contact phone number (including area code)	E-mail address: (optional)

What is being applied for (tick as applicable). In doing so you understand you may have to pay a fee for excessive copies of your records.

I am applying for access to view my health records	
I am applying for copies of my health record	
I am applying for copy of medical summary	
I am applying for copies of my investigations results e.g. blood test results, x-rays and MRI etc.	

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. Please use the space on the following page to document this information:

Dates and types of records:

Please tick the appropriate box identifying whether you or a representative on your behalf is applying for access. If you are apply on behalf of someone please make sure you provide consent of that person

I am applying to access health records on behalf of	
I have instructed my authorised representative to apply on my behalf	
I am applying for copy of medical summary on behalf	
I am applying for copies of my investigations results e.g. blood test results, x-rays and MRI etc. on behalf	

If you are the patient's representative please give details here:

Name and address of representative
Contact number and E-mail
Signature

Signature of applicant ……

Print name……

Date…….

(Office use only) Date of application received …….

Received by …….

Signed: ……. Date: ……

BIRCHDALE ROAD MEDICAL CENTRE

Patient Consent Form
for another person to access their medical records

Patient's Details **(The person whose records another individual(s) is to be given access to)**	
Surname	
First Names	
Date of Birth	
Male / Female	
Address	
Tel No.	

Details of person to be given access to this Patient's information	
Full Name	
Address	

(if more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.	
Signature	
Date	

Consent for children under 16 (Gillick Competence)
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

I am the Patient / Parent / Guardian (delete as necessary).

Signature: ……..

Full Name: ……..

Address (if not the same as patient):

……...

……