**Weobley & Staunton on Wye Surgeries**

# PATIENT SUBJECT ACCESS TO MEDICAL RECORDS (SAR) POLICY

## INTRODUCTION

On 25 May 2018 the current UK Data Protection Act 1998 (DPA 1998) was replaced by the General Data Protection Regulation (2016/679)

As with the DPA 1998, these new regulations give living individuals the right to request access to personal data held on them by the Practice. This is known as a Subject Access Request (SAR), the person whose data is held is known as the Data Subject, in many cases this will be the patient, but could be a staff member, a contractor or contact.

The law states that NHS organisations must, when requested by an individual, give that person access to their personal health information, and occasionally, certain relevant information pertaining to others. In order to do this, they must have procedures in-place that allow for easy retrieval and assimilation of this information.

There are three main areas of legislation that allow the right of the individual to request such personal information, and they are:

- The Data Protection Act 2018 (formerly DPA 1998) (DPA)
- The General Data Protection Regulation 2016 (GDPR)
- The Access to Health Records Act 1990
- The Medical Reports Act 1988

Where the request for information by an individual falls under the legislation of any of these areas, access must be granted. Patients requesting information about their own personal medical records would usually have their request dealt with under the provisions of the Data Protection Act 2018 and GDPR 2016.

Requests need not always be writing, (eg. letter, e-mail), however verbal requests should be documented, and a clarification letter sent to the patient for approval. There could also be an electronic form for requesters to complete if they prefer. SARs can also be submitted via social media, such as a practice Facebook page or Twitter.

Requesters must be either, the data subject OR have the written permission of the data subject OR have legal responsibility for managing the subject's affairs to access personal information about that person. It is the requester's responsibility to satisfy the Practice of their legal authority to act on behalf of the data subject. The practice must be satisfied of the identity of the requester before we can provide any personal information.

## NEW REQUIREMENTS FOR SUBJECT ACCESS

From 25 May 2018 new requirements were introduced affecting the handling of subject access requests. These are listed below:

**What do we need to provide to a requester?**

As well as providing confirmation that their personal data is being processed and providing a copy of the requested personal data; (subject to any exemptions), individuals will have the right to be provided with additional information which largely corresponds to the information to be provided in a privacy notice:

- Source of the data.
- Recipient, including details international transfers.
- Retention period for the data.
- How to amend inaccurate data.
- How to complain to the Information Commissioner's Office (internal review will usually need to be satisfied first).

The introduction of online patient access to services does not change the right that patients already have to request access to their medical records provided by the provisions of the Data Protection Act (DPA) and GDPR. The DPA principles and confidentiality requirements apply in the same way for online access as they do for paper copies of the record.

## TIMEFRAME FOR RESPONDING TO REQUESTS

The **Statutory** timeframe has now been reduced to at least one month of receipt of the request, and in any event **without delay** in Accordance with Article 12 of the GDPR 2016**.**

The period of compliance can be extended by a further two months where requests are determined to be 'complex' or 'numerous'.

**The fee of £10 - £50 in the previous DPA 1998 has now been removed**

GDPR **does not** allow for a fee, so it must be provided **free of charge**. However, some charges can be made in the following circumstances:

- where further copies are requested by the data subject,
- or the request is manifestly unfounded, or excessive (definitions still required by the ICO) a reasonable fee based on the organisations administration costs may be charged.

**When can a subject access request be refused?**

The Practice can decide to refuse a request where the request is 'manifestly unfounded or excessive', in particular if it is 'repetitive', and the requester must be informed of the reason why, within one month of the receipt of the request. If the practice decides to apply this option advice MUST be sought from the practice Data Protection Officer, Paul Couldrey, PCIG Consulting Limited (07525 623939).

**What format should the response be provided in?**

Where a request is received by electronic means, unless otherwise stated by the data subject, the information must be provided in a commonly used electronic format.

**What are the penalties for non-compliance with the statutory timeframe?**

The penalties are still at the discretion of the ICO. However, for non-compliance the financial penalties are now much greater. Depending on the severity of the infringement, this could be up to £17m approximately.

**A new criminal offence has been created**

If you receive a Subject Access Request, and records are altered with intent to prevent disclosure, this will be committing a criminal offence, and will be punishable by a fine.

**What should you do if you identify that you have received a SAR?**

Incoming SARs should be passed on immediately to the Administration Lead, where they will be logged, acknowledged, and processed using the SARs process form (see Appendix B).

## WHAT CONSTITUTES A HEALTH RECORD?

A health record could include, and not exhaustively, hand-written clinical notes, letters between clinicians, lab reports, radiographs and imaging, videos, tape-recordings, photographs and monitoring printouts. Records can be held in either manual or computerised forms.

NHS England has published an information leaflet Patient Online which provides further detailed information about this obligation and how patients can access their health record online.

There are occasions when a GP may firmly believe that it is not appropriate to share all the information contained in the individual's record, particularly if there is potential for such information to cause harm or distress to individuals or when the record has information relating to a third party.

Patients may request paper copies of health records and, regardless of the preferred method of access, patients and authorised third parties must initially complete a DSAR form. However, patients may request access to their health records informally; any such requests should be annotated within the individual's health record by the clinician dealing with the patient.

## MEDICAL RECORDS ACCESS – STAFF RESPONSIBILITY

**Practice Manager and Clinical Leads**

For the purposes of reviewing requests, the Administration Team, Practice Manager, Assistant Practice Manager and the responsible clinician will ensure current data protection requirements are followed. The main (but not exhaustive) duties of these roles are explained below:

**Administration Team/ IGPR**

- To process and co-ordinate the application.
- Verification of identity (See Section below)
- Reviewing the medical records for third party information and redacting information where consent has not been given.
- Reviewing the medical records for third party information and highlighting redacted information where consent has not been given for clinical review
- Contacting the patient to explain the process and inform of the outcome.

**Responsible Clinician***

- Responsibility for reviewing the medical record and limiting or redacting sensitive and/or harmful information.
- Overall responsibility for decision to allow access.
- Confirmation that record has been checked and access approved

*Responsible Clinician – the most appropriate health professional to deal with the access request is the current or most recent responsible professional involved in the clinical care of the patient in connection with the information aspects which are the subject of the request or where there is more than one such professional, the most suitable should advise.

## REQUESTS UNDER THE DATA PROTECTION LEGISLATION

Requests for information under this legislation:

- Should be made to the surgery.
- E-mail requests are allowed.
- Verbal requests can be accepted where the individual is unable to put the request in writing, or chooses not to – however a record of what is requested should be recorded and a letter for approval by the patient sent out (this must be saved on the patient record)

Requests may be received from the following:

- **Competent patients** may apply for access to their own records or authorise third-party access to their records.

- **Children and young people** may also apply in the same manner as other competent patients and the Practice will not automatically presume a child or young person has capacity under the age of 16. However, those aged 12 or over are expected to have the capacity to consent to medical information being disclosed.

- **Parents** may apply to access their child's health record so long as it is not in contradiction of the wishes of the competent child.

- **Individuals with a responsibility for adults who lack capacity** are not automatically entitled to access the individual's health records. The Practice will ensure that the patient's capacity is judged in relation to particular decisions being made. Any considerations to nominate an authorised individual to make proxy decisions for an individual who lacks capacity will comply with the Mental Capacity Act in England and Wales and the Adults with Incapacity Act Scotland.

- **Next of Kin** have no rights of access to health records.

- **Police -** In all cases the practice can release confidential information if the patient has given his/her consent (preferably in writing) and understands the consequences of making that decision. There is however, no legal obligation to disclose information to the police unless there is a court order or this is required under statues (eg. Road Traffic Act).

  The Practice does, however have a power under the DPA and Crime Disorder Act to release confidential health records without consent for the purposes of the prevention or detection of crime or the apprehension or prosecution of offenders. The release of the information must be necessary for the administration of justice and is only lawful if this is necessary:

  - To protect the patient or another person's vital interests, or
  - For the purposes of the prevention or detection of any unlawful act where seeking consent would prejudice those purposes and disclosure is in the substantial public interest (eg. where the seriousness of the crime means there is a pressing social need for disclosure).

  Only information, which is strictly relevant to a specific police investigation, should be considered for release and only then if the police investigation would be seriously prejudiced or delayed without it. The police should be asked to provide written reasons why this information is relevant and essential for them to conclude their investigations.

- **Court Representatives -** A person appointed by the court to manage the affairs of a patient who is incapable of managing his or her own affairs may make an application. Access may be denied where the GP is of the opinion that the patient underwent relevant examinations or investigations in the expectation that the information would not be disclosed to the applicant.

- **Patient Representatives/Solicitors -** A patient can give written authorisation for a person (for example a solicitor or relative) to make an application on their behalf for copies of their medical

records. The Practice may withhold access if it is of the view that the patient authorising the access has not understood the meaning of the authorisation. It is important to stress to the patient that under a SARs request all health records are provided, unless a specific time period is stated, and patients should be mindful of giving access to this level of health data.

Solicitors who are acting in civil litigation cases for patients should obtain consent from the patient using the form that has been agreed with the BMA and Law Society. If a consent form from the patient is not received with the application form then no information must be provided until this has been received.

- **Requests for Insurance/Solicitor Medical Reports -** Access to Medical Reports Act 1998 will not change and therefore these reports will still be chargeable in line with the usual recognised fee. If a consent form from the patient is not received with the application form or letter from the requester, then no information must be provided until this has been received. Insurers are to be advised that the following fees are applicable:

- **GP report for insurance applications £104.00**
- **GP Supplementary report £27.00**

All SARs and Medical Report requests must be logged on the Practice database and in the patient's medical record using the appropriate EMIS template.

- **Deceased patients** retain the right of confidentiality. There are a number of considerations to be taken into account prior to disclosing the health record of a deceased patient. Such considerations are detailed in the Access to Health Records Act 1990. Under the terms of this Act, the Practice will only grant access if you are either:

    - A personal representative (executor of the deceased person's estate); or
    - Someone who has a claim resulting from the death

The medical records of the deceased will be passed to Primary Care Support England (PCSE) for storage. The Practice can advise you of who you need to contact in such instances. PCSE will retain the GP records of deceased patients for ten years, after which time they will be destroyed. PCSE has provided an application form which can be used to request copies of a deceased patient's record.

- **IGPR** - When a request is received via iGPR, it should be processed in accordance with the Practice's iGPR protocol. iGPR will automatically find and redact items in a record that should not be included.

Additionally, to ensure all relevant attachments are included in the report (including any hard copies which are not within the patient's electronic healthcare record), the report should not be processed on iGPR until the Administration Lead is certain that the entire record has been scanned into the patient's record on EMIS. Once this has been confirmed, the request can be processed but the Administration Lead processing the request must then assign the report to the responsible clinician who will review the report and confirm accuracy before sending the report using iGPR.

A quick guide for iGPR can be accessed here.

In the cases of **any** third-party requests, Weobley & Staunton on Wye Surgeries will ensure that the patient has consented to the disclosure of this information by means of a valid signature of the patient.

In accordance with the GDPR, patients are entitled to receive a response within the maximum given time frame of one calendar month from the date of submission of the DSAR. In order to ensure full compliance regarding DSARs, the Practice will adhere to the guidance provided in the GDPR. In the case of complex or multiple requests, the data controller may extend the response time by a period of two months. In such instances, the data subject must be informed and the reasons for the extension given.

Under The Data Protection (Subject Access Modification) (Health) Order 2000, the Practice will ensure that an appropriate healthcare professional manages all access matters. At the Practice there are a number of such professionals and, wherever possible, the individual most recently involved in the care of the patient will review and deal with the request. If for some reason they are unable to manage the request, an appropriate professional will assume responsibility and manage the access request.

Furthermore, to maintain GDPR compliance, the data controller at the Practice will ensure that data is processed in accordance with Article 5 of the GDPR and will be able to demonstrate compliance with the regulation (see GDPR policy for detailed information). Data processors at Weobley & Staunton on Wye Surgeries will ensure that the processing of personal data is lawful and at least one of the following applies:

- The data subject has given consent to the processing of his/her personal data for one or more specific purposes
- Processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract
- Processing is necessary for compliance with a legal obligation to which the controller is subject
- Processing is necessary in order to protect the vital interests of the data subject or another natural person

For providing a copy of a deceased patient's medical records, a fee not exceeding the cost of making the copy and postal costs may be charged; this fee must be reasonable and fully justifiable.

## PROCEDURE FOR ACCESS

A Data Subject Access Request Form should be completed and passed to the data controller. All DSARs should be processed free of charge unless they are either complex, repetitive or unfounded (see GDPR Policy). The GDPR states that data subjects should be able to make access requests via email. Weobley & Staunton on Wye Surgeries is compliant with this and data subjects can complete an e-access form and submit the form via email.

Upon receipt of a DSAR, the Administration Lead will record the DSAR within the health record of the individual to whom it relates (following the EMIS template), as well as annotating the DSAR log. Furthermore, once processed, an entry onto the health record should be made, including the date of postage or the date the record was collected by the patient or authorised individual.

The Responsible Clinician will review the content of the medical record and ensure that sensitive or harmful data are not made available to the patient. The Responsible Clinician may redact sensitive or harmful data if they consider it to be in the patients' best interest.

The Responsible Clinican can refuse the request for the reasons set out in the section below regarding Denial or Limitation of Information.

The Responsible Clinician will also check the record for quality, clarity of presentation, completeness, and accuracy.

The use of the practice's Data Subject Access Request (DSAR) form supports the data controller in verifying the request.

## PROXY ACCESS TO MEDICAL RECORDS

Proxy access is when an individual other than the patient has access to an individual's medical record on their behalf to assist in their care. Proxy access arises in both adults and children and is dealt with differently according to whether the patient has capacity or not.

The patient's proxy should have their own login details to the patient's record. If a patient wants to have

more than one proxy, they should all have their own personal login details. In the current version of our electronic records system (EMIS) login details will be shared between the patient and the individual with proxy access. Proxy access should not be granted where:

- The practice suspects coercive behaviour. (See section regarding coercion below)
- There is a risk to the security of the patient's record by the person being considered for proxy access.
- The patient has previously expressed the wish not to grant proxy access to specific individuals should they lose capacity, either permanently or temporarily; this should be recorded in the patient's record.
- The Responsible Clinician assesses that it is not in the best interests of the patient and/or that there are reasons as detailed in Denial or Limitation of Information.

**Proxy Access In Adults (Including Those Over 13 Years Of Age) With Capacity**

Patients over the age 13 (under UK DPA 2018) are assumed to have mental capacity to consent to proxy access. Where a patient with capacity gives their consent, the application should be dealt with on the same basis as the patient.

In terms of online access, it may be possible to give the proxy different levels of access depending on the wishes of the patient and/or the views of the Responsible clinician. For example, some patients may want to allow a family member to have access only to book appointments and order repeat prescriptions without accessing the detailed care record.

**Proxy Access In Adults (Including Those Over 13 Years Of Age) Without Capacity**

Nursing/ Residential homes will not be granted proxy access for patients under their care. Proxy Access without the consent of the patient may be granted in the following circumstances:

- The patient has been assessed as lacking capacity to make a decision on granting proxy access and has registered the applicant as a lasting power of attorney for health and welfare with the Office of the Public Guardian.

- The patient has been assessed as lacking capacity to make a decision on granting proxy access, and the applicant is acting as a Court Appointed Deputy on behalf of the patient

- The patient has been assessed as lacking capacity to make a decision on granting proxy access, and in accordance with the Mental Capacity Act 2005 code of practice, the Clinical Lead considers it in the patient's best interests to grant access to the applicant.

- When an adult patient has been assessed as lacking capacity and access is to be granted to a proxy acting in their best interests, it is the responsibility of the Clinical Lead to ensure that the level of access enabled or information provided is necessary for the performance of the applicant's duties.

**Proxy Access In Children Under The Age Of 11**

All children under the age of 11 are assumed to lack capacity to consent to proxy access. Those with parental responsibility for the child can apply for proxy access to their children's medical records. Parents will apply for access through the same process outlined above. Additional identification of Parental/Guardian evidence will be required.

**Proxy Access In Children Above The Age Of 11 And Under 13 Years Of Age**

Access to medical records will need to be assessed on a case by case basis. Some children aged 11 to 13 have the capacity and understanding required for decision-making with regards to access to their medical records and should therefore be consulted and have their confidence respected.

Online proxy access will automatically be turned off when a child reaches the age of 11. Online proxy access to the Detailed Coded Record of children aged 11 to 13 will not normally be approved unless it is in the best interests of the child or is the express wishes of a competent child.

The Responsible Clinician will invite the child for a confidential consultation to discuss the request for proxy access whether this is for requests under the Data Protection Law or for online access.

The Responsible Clinician should use their professional judgement in deciding whether to grant parental access and/or whether to withhold information.

If the practice suspects coercive behaviour access will be refused and documented in the medical notes. The Responsible Clinician will liaise with Child Safeguarding teams if appropriate

Online proxy access will also be turned off when a child turns 13. Access can be turned back on by following the processes set out above governing access to adults.

## COERCION

Coercion is the act of governing the actions of another by force or by threat, in order to overwhelm and compel that individual to act against their will.

Online access to records and transactional services provides new opportunities for coercive behaviour. If the practice suspects coercive behaviour for either an individual or proxy access application, then access will be refused and documented in the medical notes. The Responsible Clinician will liaise with the Safeguarding Team if appropriate.

## IDENTITY VERIFICATION

Before access to health records is granted, the patient's identity must be verified. There are three ways of confirming patient identity:

- Documentation (Forms of Identification)
- Vouching
- Vouching with confirmation of information held in the applicant's records

All applications for access to health records will require formal identification through 2 forms of ID one of which must contain a photo. Acceptable documents include passports, photo driving licences and bank statements, but not bills.

Where a patient may not have suitable photographic identification – Vouching with confirmation of information held in the medical record can be considered by the Administrative Lead or Responsible Clinician. This should take place discreetly and ideally in the context of a planned appointment. It is extremely important that the questions posed do not incidentally disclose confidential information to the applicant before their identity is verified.

**Adult Proxy Access Verification**

Before the practice provides proxy access to an individual or individuals on behalf of a patient further checks must be taken:

- There must be either the explicit informed consent of the patient, including their preference for the level of access to be given to the proxy, or some other legitimate justification for authorising proxy access without the patient's consent
- The identity of the individual who is asking for proxy access must be verified as outlined above.

- The identity of the person giving consent for proxy access must also be verified as outlined above. This will normally be the patient but may be someone else acting under a power of attorney or as a Court Appointed Deputy.
- When someone is applying for proxy access on the basis of an enduring power of attorney, a lasting power of attorney, or as a Court Appointed Deputy, their status should be verified by making an online check of the registers held by the Office of the Public Guardian.

**Child Proxy Access Verification**

Before the practice provides parental proxy access to a child's medical records the following checks must be made:

- The identity of the individual(s) requesting access via the method outlined above.
- That the identified person is named on the birth certificate of the child.
- In the case of a child judged to have capacity to consent, there must be the explicit informed consent of the child, including their preference for the level of access to be given to their parent.

## ADDITIONAL PRIVACY INFORMATION NOTICE

Once the relevant information has been processed and is ready for issue to the patient, it is a requirement, in accordance with Article 15 of the General Data Protection Regulation (GDPR) to provide an Additional Privacy Information Notice.

## THIRD PARTY INFORMATION

Patients' records may contain confidential information that relates to a third person. This may be information from or about another person. It may be entered in the record intentionally or by accident.

It does not include information about or provided by a third party that the patient would normally have access to, such as hospital letters.

All confidential third-party information must be removed or redacted. This will be reviewed and highlighted by the Administrative Lead. If this is not possible then access to the health records will be refused.

## DENIAL OR LIMITATION OF INFORMATION

Access to any health records can be denied or limited in scope of information. This decision will be made by the Practice Manager for the practice.

Access will be denied or limited where in the reasonable opinion of the Responsible Clinician, access to such information would not be in the patient's best interests because it is likely to cause serious harm to:

- The patient's physical or mental health, or
- The physical or mental health of any other person
- The information includes a reference to any third party who has not consented to its disclosure

A reason for denial of information must be recorded in the medical records and where possible and appropriate an appointment will be made with the patient to explain the decision.

## STAFF TRAINING AND EDUCATION

All staff at the practice will be required to read the policy and confirm their understanding.

All staff will be encouraged to undertake the E-learning programmes provided by Bluestream Academy. For the Administrative Team, Practice Manager, Assistant Practice Manager and Responsible Clinical Leads this will be mandatory.

## FORMER NHS PATIENTS LIVING OUTSIDE THE UK

Patients no longer resident in the UK still have the same rights to access their information as those who still reside here and must make their request for information in the same manner. If the patient is no longer registered at the Practice they should be advised to contact Primary Care Support Services England (PCSE) who manages the service for NHS England. – the data controller for unregistered or deceased patients. If the patient is registered, the request can be completed and then the patient should be de-registered.

Original health records should not be given to an individual to take abroad with them, however, the Practice may be prepared to provide a summary of the treatment given whilst resident in the UK.

## DISPUTES CONCERNING CONTENT OF RECORDS

Once access to medical records has been granted patients may dispute their accuracy or lack understanding of medical codes.

Patients may notice and point out errors in their record, unexpected third-party references, entries they object to or want deleted. The right of rectification and deletion are now established within the GDPR.

Reception Staff will pass on any queries to the Practice Manager or Assistant Practice Manager who will contact the patient.

The Practice Manager will investigate swiftly and thoroughly to identify the source and extent of the problem.

The Practice Manager will then decide on the most appropriate action. Where the dispute concerns a medical entry the clinician who made the entry should be consulted and consideration given as to whether it is appropriate to change or delete an entry. Where it is not possible or practical to contact the clinician concerned the Caldicott Guardian should be consulted. If it is not possible to amend the records a meeting with the patient should be organised to explain why.

If a patient wishes to apply their GDPR 2016 rights of

- Rectification (Article 16 GDPR)
- Erasure (Article 17 GDPR)
- Restriction of Processing (Article 18 GDPR)
- Data Portability (Article 20 GDPR)

**Advice MUST be sought from the practice Data Protection Officer, Paul Couldrey, PCIG Consulting Limited (07525 623939)**

The final decision surrounding the accuracy of the medical record will be the responsibility of the clinician who made the entry. Where it is not possible or practical to contact the relevant clinician the Caldicott Guardian will decide to amend the record if appropriate. Where it is not appropriate, an entry may be made declaring that the patient disagrees with the entry. If the patient further disputes the accuracy once a decision has been made they will be referred to the complaints procedure and/or the Health Ombudsmen.

## COMPLAINTS

The practice has procedures in place to enable complaints about access to health records requests to be addressed. Please refer to our Practice Complaints Policy.

**All complaints about Access to Records should be referred to the practice Data Protection Officer, Paul Couldrey, PCIG Consulting Limited (07525 623939)**

If the issue remains unresolved, the patient should be informed that they have a right to make a complaint through the NHS complaints procedure (further information is available at:

http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/what_to_do.aspx

Sometimes the patient may not wish to make a complaint through the NHS Complaints Procedure and instead, take their complaint direct to the Information Commissioner's Office (ICO) if they believe the Practice is not complying with their request in accordance with the Data Protection Act. Alternatively, the patient may wish to seek legal independent advice.

## Confidentiality Notice

This document and the information contained therein is the property of **The Weobley & Staunton-On-Wye Surgeries**. This document contains information that is privileged, confidential or otherwise protected from disclosure. It must not be used by, or its contents reproduced or otherwise copied or disclosed without the prior consent in writing from **The Weobley & Staunton-On-Wye Surgeries**.

**Document Revision and Approval History**

| Version | Date | Version Created By: | Version Approved By: | Comments |
|---|---|---|---|---|
| 1.0 | 18.10.13 | Michele Petrie | Michele Petrie | |
| 2.0 | 21.01.15 | Michele Petrie | Michele Petrie | Updated procedures and legislative requirements |
| 3.0 | 13.03.18 | Michele Petrie | Michele Petrie | Updated legislation |
| 4.0 | 12.06.19 | Michele Petrie | Michele Petrie | Updated legislation and processes |
| 4.1 | 13.03.24 | Suzi Prince | Suzi Prince | Updated fees |

**Appendix A**

**Weobley & Staunton on Wye Surgeries**

# DATA PROTECTION ACT 1998
# SUBJECT ACCESS TO MEDICAL RECORDS REQUEST

## Section 1 - Details Of The Record To Be Accessed:

| | |
|---|---|
| **Patient Surname** | |
| **Forename(s)** | |
| **Address** | |
| **Date of Birth** | |
| **NHS Number** | |

**If you are applying to view your own records please go to Section 2. If you are applying to view another person's record please go to Section 3.**

## Section 2 - Details of the Application

**To be completed if you are the Patient named above:**

| | |
|---|---|
| I confirm I am the patient named above | ☐ |
| I am applying for access to view my records only | ☐ |

| | |
|---|---|
| I am applying for copies of my medical record | ☐ |
| I have instructed someone else to apply on my behalf and have indicated below if there are any limitations to access. | ☐ |

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

| **Patient Signature** | | **Date** | |
|---|---|---|---|

## Section 3 - Details Of The Person Who Wishes To Access The Records

**To be completed if you are requesting access on behalf of the Patient named above:**

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

(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)

## Which of the following statements apply:

| | |
|---|---|
| | |

| | |
|---|---|
| I have been asked to act by the patient and they have signed the declaration below | ☐ |
| 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). | ☐ |

**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 records referred to above under the terms of the Data Protection Act 1998.

I agree to pay the appropriate fee for the disclosure required, if appropriate.

| | | | |
|---|---|---|---|
| **Applicant Signature** | | **Date** | |

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

## Section 4 – Records Required

- Under the Data Protection Act 1998 you do not have to give a reason for applying for access to your health records.
- You will be asked to provide photographic identification
- Please use this space below to inform us of certain periods and parts of the 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.

| | |
|---|---|
| I would like a copy of all records | ☐ |

| | |
|---|---|
| I would like a copy of records between specific dates only (please give date range) below | ☐ |
| I would like copy records relating to a specific condition/specific incident only (please detail below) | ☐ |

## Section 5 - 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** | |
| **Date** | |

Weobley & Staunton on Wye Surgeries

**Appendix B**

# SUBJECT ACCESS REQUEST – COPIES OF MEDICAL RECORDS (PRACTICE PROCESSES)

| | | | |
|---|---|---|---|
| **Date Received** | | **Date Due to be Completed (28 days)** | |

## PATIENT

| | | | |
|---|---|---|---|
| **Surname** | | **Forenames** | |
| **Date of Birth** | | **EMIS No** | |
| **Address** | | | |
| **Email** | | | |

## REQUESTOR

| | |
|---|---|
| **Name** | |
| **Address** | |
| **Email** | |

**How was the request made?** If request received electronically, information should be provided in a commonly used electronic format.

| | | | |
|---|---|---|---|
| In Writing ☐ | Email ☐ | Verbally ☐ | Other ☐ |

## ACCESS DETAILS

| | |
|---|---|
| **Access under General Data Protection Regulations 2016/679** (Free) | Yes ☐ No ☐ |
| **Access to Medical Reports Act (AMRA) 1990** (Chargeable) ie. reports for employment and insurance purposes includes cover for accident claims, insured negligence, mortgage and life insurance. Anything covered by an insurance contract to support actual or potential insured claim then AMRA applies.<br><br>If the requestor letter does not specify precise purpose of request contact requestor to clarify via standard letter.<br><br>Response: | Yes ☐ No ☐<br><br>Date Sent:<br><br>Date: |

## DETAILS OF REQUEST

| | | | | |
|---|---|---|---|---|
| **Entire Medical Records** | Yes ☐ No ☐ | | | |
| **Dates** | **From** | | **To** | |

## VERIFICATION OF AUTHORITY/PATIENT CONSENT

| | |
|---|---|
| **Requestor's Identity Confirmed** | Yes ☐ No ☐ |
| **Requestor's Legal Authority Confirmed** | Yes ☐ No ☐ |
| **Patient's Identity Verified** | Yes ☐ No ☐ |
| **If Patient does not have capacity – verify:** | |
| Enduring Power of Attorney | Yes ☐ No ☐ |
| Lasting Power of Attorney for Health & Welfare | Yes ☐ No ☐ |
| Court Appointed Deputy | Yes ☐ No ☐ |

## CONTACT WITH PATIENT

| | |
|---|---|
| **Date of Patient Contact** | |
| Need to inform the patient *'It is my duty to discuss the recent request made by…… with you and to advise you what information will be provided, that we hold for you on your computer records and in your paper records. It is your choice to decide the amount of information we provide to the requestor – this can be your entire medical records or from a specific date'.* | |
| **Discussed type of information held by the Practice which can include:** | |
| Demographic Data | Yes ☐ No ☐ |
| Diagnoses & Investigation Results | Yes ☐ No ☐ |
| Procedural and consultation information recorded by Practice and Ancillary colleagues, eg. District nurse, Health Visitor | Yes ☐ No ☐ |
| Immunisations and medications | Yes ☐ No ☐ |
| All letters | Yes ☐ No ☐ |
| Sensitive Information – Sexual health and mental health access | Yes ☐ No ☐ |
| All third party information will be removed ie. any references to named individuals – spouses, children etc | Yes ☐ No ☐ |
| Patient Confirms Requestors Request | Yes ☐ No ☐ |
| If No – details of patient's new request | Yes ☐ No ☐ |

| | |
|---|---|
| | |

## CONFIDENTIAL THIRD PARTY INFORMATION REMOVED/REDACTED

| | |
|---|---|
| **Yes ☐** | Details of information removed – |
| **No ☐** | |

## IF SUBJECT ACCESS REQUEST REFUSED

| | | | |
|---|---|---|---|
| **Contact Practice Data Protection Officer – Paul Couldrey, PCIG Consulting Ltd – Telephone: 07525 623939** | | | |
| **Date of Contact with Data Protection Officer** | | **Date of Refusal Letter** | |

## GP CONFIRMATION FOR RELEASE OF MEDICAL RECORDS

| | | | |
|---|---|---|---|
| **Name of Clinician** | | | |
| **Request Authorised** | | Yes ☐ No ☐ | |
| **Patient Details Validated** | | Yes ☐ No ☐ | |
| **Copies of Medical Records validated for third party information, sensitive information and redaction complete** | | Yes ☐ No ☐ | |
| **Request authorised for release** | | Yes ☐ No ☐ | |
| **Clinician Signature** | | **Date** | |

## PATIENT NOTIFIED FOR COLLECTION

| | | | |
|---|---|---|---|
| **Date Pt Notified** | | **Notified By** | |
| No later than 30 days from the date requested | | | |

## COLLECTION OF COPIES OF MEDICAL RECORDS

| | | | |
|---|---|---|---|
| I confirm receipt of copies of the medical records regarding the above-named and understand that I am now responsible for keeping them and the information contained therein safe and secure. If I believe or suspect that the information has been accessed without my agreement, I will contact the practice as soon as possible to record this on my records | | | |
| **Name of Staff member handing over Records** | | **Signature** | |

| | | | |
|---|---|---|---|
| **Date** | | **Time** | |
| | | | |
| **Person Receiving Records** | | **Signature** | |
| **Date** | | **Time** | |
| | | | |
| **Type of Identity – ID1** | | **Confirmed By** | |
| **Type of Identity – ID2** | | **Confirmed By** | |

| | |
|---|---|
| **Date of Completed Request** | |

**Please ensure that any information is put into a sealed plastic envelope before handing/posting to the requestor.**

Please pass form for scanning into notes when completed. Once scanned, form can be destroyed.