York Medical Group

Patient Access to Medical Records - Request Form

Access to Health Records under the Data Protection Act 2018 (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: (Please provide GP name, Practice address and contact details here)

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:

What is being applied for (tick as applicable).

I am applying for access to view my health records.	
I am applying for copies of my health record.	
I have been asked to act by the patient and attach the patient's written consent.	
I am acting in loco Parentis and the patient is under sixteen, and *is incapable of understanding the request/ has consented to me making this request (*delete as appropriate).	
I am the patient's legal representative or Executor/Administrator of the will and attach confirmation of my appointment.	

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

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

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.

For children aged 11 to 15 parent and child consent together is required.

If the child is not able to give consent ie under the age of 11, 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):

……

……..

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

Signature: ……
Full Name: ……

Address (if not the same as patient):

……

……..

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:

Signature of applicant …….

Print name…….

Date……..

Please return completed Subject Access Request form either via email to hnyicb-voy.ymgmedreports@nhs.net or in person to any of our open surgeries

All records will be securely emailed unless you are unable to receive them in this manner. Paper copies must be collected in person by the requester and 2 forms of ID (as above) must be presented on collection.