ENDERLEY ROAD MEDICAL CENTRE

41-45 Enderley Road, Harrow Weald, Middlesex, HA3 5HF

Annex A - APPLICATION FORM FOR ACCESS TO HEALTH RECORDS in accordance with the General Data Protection Regulation (GDPR) DATA SUBJECT ACCESS REQUEST

This form must be completed in blue or black ink and signed in order for us to process your request.

Section 1: Patient details

Surname		**Maiden name**	
Forename		**Title (i.e. Mr, Mrs, Ms, Dr)**	
Date of birth		**Address:**	
Telephone number		**Postcode:**	
NHS number (if known)		**Hospital number (if known)**	

Section 2: Record requested

The more specific you can be, the easier it is for us to quickly provide you with the records requested.
Record in respect of treatment for: (e.g. leg injury following a car accident)

Please provide me with a copy of all records held **Medical Summary** ☐ **Full Electronic Medical Records** ☐ **Full Electronic Records + Paper Records** ☐	
Please provide me with a copy of records between the dates specified below:	
Please provide me with a copy of records relating to the incident specified below:	
Please provide me with a copy of records relating to the condition specified below:	

Section 3: Details and declaration of applicant

Please enter details of applicant if different from Section 1

Surname		**Title (Mr, Mrs, Ms, Dr)**	
Forename(s)		**Address**	
Telephone number		**Postcode**	

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 GDPR.

Please tick:

☐ I am the patient

☐ I have been asked to act by the patient and attach the patient's written authorisation

☐ I have full parental responsibility for the patient and the patient is under the age of 18 and:
(a) has consented to my making this request, or
(b) is incapable of understanding the request (delete as appropriate)

☐ I have been appointed by the court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so

☐ I am acting *in loco parentis* and the patient is incapable of understanding the request

☐ I am the deceased person's Personal Representative and attach confirmation of my appointment (Grant of Probate/Letters of Administration)

☐ I have written, and witnessed, consent from the deceased person's Personal Representative and attach Proof of Appointment

☐ I have a claim arising from the person's death (Please state details below)

TRANSMISSION OF RECORDS

YOUR MEDICAL RECORDS WILL BE EMAILED TO YOU SECURELY. PLEASE PROVIDE AN EMAIL ADDRESS TO WHICH YOU WISH US TO SEND YOUR MEDICAL RECORDS. PLEASE PRINT AND SIGN THIS DOCUMENT AND RETURN IT TO THE SURGERY BY HAND OR POST. YOUR REQUEST MUST INCLUDE PROOF OF ID OR IT WILL BE REJECTED.

EMAIL ADDRESS: ……..

Signature of applicant: .....

Date: ……..

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Section 4:
Proof of identity
Please indicate how proof of ID has been confirmed. Please select 'A' or 'B':

	Method in which identity is confirmed	**Option taken**	**Documents attached**
A	Attached copies of documents as noted in section 4A below	Yes/No	If Yes, please indicate here which documents have been attached
B	Countersignature (section 4B). This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided)	Yes/No	Please indicate reason why this section was completed

4A – Evidence

Evidence of the patient's and/or the patient's representative identity will be required. Please attach copies of the required documentation to this application form. Examples of required documentation are:

	Type of applicant	Type of documentation
A	An individual applying for his/her own records	One copy of identity required, e.g. copy of birth certificate, passport, driving licence, plus one copy of a utility bill or medical card, etc.
B	Someone applying on behalf of an individual (Representative)	One item showing proof of the patient's identity and one item showing proof of the representative's identity (see examples in '**A'** above)
C	Person with parental responsibility applying on behalf of a child	Copy of birth certificate of child & copy of correspondence addressed to person with parental responsibility relating to the patient
D	Power of Attorney/Agent applying on behalf of an individual	Copy of a court order authorising Power of Attorney/Agent plus proof of the patient's identity (see examples in '**A'** above)

4B – Countersignature
This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section may be completed if 4A cannot be fulfilled.

I (insert full name).....

Certify that the applicant (insert name).....

Has been known to me personally as ..... for .....years
(Insert in what capacity, e.g. employee, client, patient, relative etc.)

and that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed .....Date .....

Name ..... Profession .....

Address .....

Daytime telephone number .....

Additional notes

Before returning this form, please ensure that you have:

a) signed and dated this form

b) enclosed proof of your identity or alternatively confirmed your identity by a countersignature

c) enclosed documentation to support your request (if applying for another person's records)

Incomplete applications will be returned; therefore please ensure you have the correct documentation before returning the form.

We will aim to process the request within one calendar month.