APPLICATION TO RECORDS

PATIENT INFORMATION

Name: ..... Date Of Birth .....

Phone: ..... Email .....

Address: .....

PLEASE SPECIFY WHAT INFOMATION YOU ARE REQUESTING

Please write what is needed .....

.....

Particular medical condition .....

Reason for the request .....

.....

How will this help .....

.....

Dates From ..... to .....

IF REQUESTION FOR SOMEONE ELSE

Name: ..... Relation To patient: .....

Reason for access: .....

*Patient Consent Signature** .....

SUBJECT ACCESS REQUEST

SPECIFICATION

We no longer print medical records, however we are able to provide an electronic copy via email or USB. You can then share and/or print as required.
Records can also be accessed via online access.
Allow up to 30 days for records

- I Understand that it is my responsibility to ensure the security of the information I see or download
- Any information I share is done so at my own risk
- If I suspect someone without my consent has accessed my details, I will contact the surgery immediately
- If the information on my record is inaccurate, I will contact the surgery as soon as possible
- I have read and understood the Access Information Leaflet.
- I understand that I cannot request personal data from anyone else unless I am a parent/ Guardian of a child under 13
- 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 records/information referred to under the terms of the Data Protection Act 1998 / Access to Health Records (NI) Order 1993 Your

Printed Name: Signature:

Date:

ID Provided ◯

AUTHORISATION

Records Sent ◯ If not granted state the reason

Dates Sent/ Collected Patient signature on collection