WICKHAM PARK SURGERY

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**Access to Patient Health Records Request Form**

Please use this form to request a full or partial copy of you medical record. Please note that this is a request for a ***printed paper copy***of medical records. If you wish to access your records online please fill out the Online Access Request form. Applications for access to printed records may take up to a maximum of 30 days as set out in GDPR guidelines but we aim to have these ready within 2 weeks.

**Details of the record to be accessed:**

|  |  |
| --- | --- |
| Patient Surname |  |
| Forename(s) |  |
| Date of Birth |  |

**Details of the person who wishes to access copies of the records, if different to above:**

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

**Tick which of the following statements apply:**

* I am the patient.
* I am acting on behalf of the patient and have power of attorney over health and wellbeing (must be documented on patients medical records)
* 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).

**Notes:**

Under the Data Protection Act 1998 you do not have to give a reason for applying for access to your health records.

Please use the space below to inform us of certain periods and parts of your health record you are requesting, or provide more information. This will help us to process your application quicker.

This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports.

If you do not provide information about which medical records you require below the secretary may have to contact you to confirm which part of the records you would like access to, which may delay your request.

**Records Requested:**

* Entire medical record
* Records between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Records regarding (eg, specific health condition or diagnosis. Continue on a separate page if needed)

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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.

**Patient’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person requesting copies of medical records, aged over 16 (including parents/guardians)**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**