Patient Access to Medical Records - Request Form

(Subject Access Request)

Please note all requests will be dealt within one month (30 days) unless otherwise communicated.
Excessive requests maybe subject to a fee.

Identity of individual about whom information is requested
(Please print all details)

Full Name	Former name(s)
Current address Post Code:	Former address (with dates of change)
Date of birth	CHI number (if known)
Contact phone number (including area code)	E-mail address: (optional)
We will contact you on the above number to either arrange appointment to view your records or to let you know when your records are ready to collect. Are we able to leave a message on the above number if you are unavailable? **Yes**☐ **No**☐	
If the number above is a mobile phone, would you like us to update your records (if applicable) so that you receive text message appointment reminder and other health messages, communications and reminders from us? **Yes**☐ **No**☐	

What is being applied for (tick as applicable).
Please note that excessive requests maybe subject to a fee.

I am applying for access to view my medical records	
I am applying for copies of my medical records between the following dates From:_____ To:_____	
I am applying for a full copy of my medical records that is held in the practice	

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.

Dates and types of records:

Please tick the appropriate box identifying whether you or a representative on your behalf is applying for access.

I am applying to access my health records ☐

I have instructed my authorised representative to apply on my behalf and I consent to the practice communicating with this person regarding my medical records ☐

I am applying as the patient is under 13 and I am their parent/ guardian ☐

Signed:_____ Date:_____

*Please hand this form into reception along with **2 forms of ID** (e.g. passport or photo driving licence plus utility bill or council tax bill)*

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

Full Name:_____

Address:_____

_____

_____ Postcode:_____

Contact number (including area code)and E-mail	E-mail address: (optional)
Relationship to patient e.g. Friend, parent etc.	

Signed:_____ Date:_____

Please note that the above still applies regarding ID for the patient. In addition the representative will be required to produce photographic ID if medical records are to be viewed/ collected.

Consent for Children Under 13

Everyone aged 13 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If you're under 13, your parent or guardian must apply to see your records on your behalf or consent to a representative. Please see www.nhsinform.scot for further information.

For Practice Use Only

Date of application received: _____

ID Documents Verified:	1.		
	2.		
Received by:		Signed:	Date:
Passed to Medical Secretaries ☐ Date:			