Grŵp Meddygol argyle Medical Group

Application for Access to Health Records

Please complete this form if you wish to access your medical records. You are entitled to either read or be sent copies of your health records within 30 days of your original request.

You can also use this form, if you are making a request on behalf of someone else, however in such instances we will ask you to provide evidence of your entitlement to act and receive information (please ensure you complete section 3) or will seek authority from the individual for whom you have made the request.

You will not be charged for a copy of your records. However, the Practice can charge a "reasonable fee" when a request is manifestly unfounded or excessive, particularly if it is repetitive. We will therefore charge a reasonable fee to comply with requests for further copies of the same information.

Section 1: Details of the individual for whom the request relates

Name:	
Address & Post Code:	
Date of Birth:	
NHS Number (if known):	
Contact Telephone Number:	

In order, to protect your information, we are unable to respond to a request unless we have confirmed your identity. Please provide one form of identification. If you are posting copies to us, please ensure these are appropriate, alternatively please attend the practice with original documents.

Documents that can be used as proof of Identity: **(please tick as appropriate)**

1. Current signed passport	
2. Residence permit issued by the Home Office	
3. EU or Swiss national identity photo-card	
4. Valid UK photo-card driving licence (full or provisional)	
5. Valid armed or police forces photographic identity card	
6. Photographic disabled blue badge	
7. Recent original utility/council tax bill	
8. Hospital appointment letter	
9. Bank/building society statement	

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Section 2: Whose personal data are you requesting? (please tick as appropriate)

	I am the patient named in section 1 ***(please proceed to section 3)***
	I have a signed letter of authority to make this request. ***(please enclose a copy of signed authority)***
	I have parental responsibility for the patient who is under the age of 16 (***please enclose a copy of proof of parental responsibility i.e. parental responsibility order issued by the Court or a copy of the Childs full birth certificate***) **Please note:** that you do not have an automatic right to your child's data, and decisions will be made on the relevance of release of data to you. In the UK a child aged 13 years or older in most circumstances will be required to consent to the release of their data.
	I have been appointed through a Lasting Power of Attorney to act on behalf of the patient (***N.B. proof must be enclosed before the application can be processed i.e. a copy of the sealed document)***
	I am the deceased patient's Personal Representative ***(proof must be enclosed before the application can be processed i.e. Grant of Probate or proof that you are the Executor of the Will)***
	Other Reasons (please outline)

If you are **not** requesting access to your own personal data, please provide the following information about you:

Name:	
Address & Post Code:	
Date of Birth:	
Contact Telephone Number:	
Relationship to individual for whom you are requesting data:	

PLEASE NOTE:

We are unable to respond to your request until we also receive the following:

- Satisfactory confirmation of the identity of the person on whose behalf you are making this request. Please provide details outlined in section one.
- A copy of your legal authority to make this request. This may be a signed letter of authority, a power of attorney document or other legal document confirming you are their legal representative.

Section 3: What data are you requesting?

Please provide as much detail as possible as to the data you are requesting. Please be as specific as possible as this will speed up the request process, include time periods and specific episodes of illness or treatment wherever possible.

I declare that the information given in this form is correct to the best of my knowledge and that I am entitled to apply for access to the records referred to under the terms of the UK General Data Protection Regulation (UK GDPR) 2016, Access to Records Act 1990 or the Mental Capacity Act 2005.

Please check the information you have provided and sign below:

Full name of Applicant:	
Signature of Applicant:	
Date:	

Please return this form and the documents we have asked you to provide to either Argyle Street Surgery or St Oswalds Surgery.

For Office Use Only:

Identification Document/ Proof of Address Documents Provided:	Identification verified by:	Date:

Where the individual making the request is a representative of the patient a copy of relevant authorisation/ entitlement is attached: YES/NO