**Details of Record to be accessed:**

|  |  |
| --- | --- |
| Patient Surname: | NHS Number: |
| Forename(s) | Address |
| Date of Birth: |  |

**Details of Person who wishes to access the records, if different from above:**

|  |  |
| --- | --- |
| Surname | Address: |
| Forename |  |
| Telephone Number | Relationship to Patient |

**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 General Data Protection Regulation (GDPR). I understand that, under the terms of the Regulation, the practice has 30 calendar days in which to respond to this request, with day 1 being the day the practice receives this request.

Details of my Application (please **tick** as appropriate) **patient to complete:**

|  |  |
| --- | --- |
| I am applying for access to view my Surgery records only |  |
| I am applying for a copy of my ENTIRE medical record that Riverside Surgery hold (For some letters, investigations from other hospitals you will need to apply directly to that hospital). |  |
| **I will supply photographic ID when I collect the requested information** |  |
| I agree to pay the appropriate fee if the request is manifestly unfounded or excessive – we will inform you if this fee is applicable.  |  |

*Under General Data Protection Regulation (GDPR) you do not have to give a reason for applying for access to your health records. For further details regarding your patient rights, please ask to see our Privacy Notice (which is viewable at* [*www.theriversidesurgeryhighwycombe.nhs.uk*](http://www.theriversidesurgeryhighwycombe.nhs.uk) *or at our Surgery)*

**Note:** **If the request is manifestly unfounded or excessive charges will apply**

**Please tick** whichever statement applies:

* I am the patient
* I have been asked to act by the patient and attach the patients written authorisation
* 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).

Print Name: ……………………………………………….

Signed: ……………………………………………………. Date…….…………………………

**Please hand this form into Reception and bring photographic identification with you when you collect your requested information.**

**Note:** **If the request is manifestly unfounded or excessive charges will apply**

**Optional** – If you are requesting your ENTIRE medical records please use the section above.

If you are only requesting specific information from your medical records, please inform us by completing the below section. This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports.

Note:

1. You may be contacted by the practice for further information or clarification about the request if needed using the contact information you have provided.
2. If specific information is requested, Riverside Surgery will redact any third party information (excluding health professionals) and any information which may cause the subject (patient) or another person serious harm (physical or mental)
3. If the request is manifestly unfounded or excessive charges will apply and you will be notified of this in writing.

|  |  |
| --- | --- |
| I would like a copy of records between specific dates only (please give date range): |  |
| I would like a copy of records relating to a specific condition(s) /specific incident(s) (please detail) |  |
| I would like a copy of hospital letters we may hold (please specify dates, conditions they relate to). |  |
| Any other comments you may wish to make: |  |

**Please be aware that Riverside Surgery does not hold your entire NHS medical records. For some information, you will need to contact the Hospitals directly to gain access to your medical records held by them.**

**Please hand this form into Reception and bring photographic identification with you when you collect your requested information.**