Patient Access to Medical Records - Request Form

(Subject Access Request)

<u>Please note all requests will be dealt within one month (30 days) unless otherwise communicated.</u>

<u>Excessive requests maybe subject to a fee.</u>

Identity of individual about whom information is requested

(Please print all details)

(ricase print an actains)						
Full Name	Former name(s)					
Current address	Former address (with dates of change)					
	, , , , , , , , , , , , , , , , , , , ,					
Post Code:						
Date of birth	CHI number (if known)					
Contact phone number (including area code)	E-mail address: (optional)					
contact phone namber (metading area code)	2 man address. (optional)					
We will contact you on the above number to either		to let				
you know when your records are ready to collect. A number if you are unavailable? Yes No	re we able to leave a message on the above					
If the number above is a mobile phone, would you I	ike us to update your records (if applicable) so	o 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	o a fee.					
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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 <u>2 forms of ID</u> (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 quardian 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:								