SUBJECT ACCESS REQUEST

To request access to medical records

SECTION 1 – Patient Details

Surname: ……

Forename: ……

Address: …… **Date of Birth:** ……
……
……
……

Day time telephone number: ……
Mobile telephone number: ……

SECTION 2 – Third Party Details *(if not the patient making this request)*

Surname: ……

Forename: ……

Address: …… **Date of Birth:** ……
……
……
……

Day time telephone number: ……
Mobile telephone number: ……

Relationship *(i.e. Mother, Brother, Husband, etc.)* ……

SECTION 3 - Tick whichever of the following statements apply (there can be more than one):

- o I am the patient
- o I have been asked to act by the patient and I attach the patient's written authorisation.
- o I am acting in Loco Parentis as the patient is under age sixteen and is incapable of understanding the request/has consented to me making this request.
- o I am the deceased patient's personal representative or executer of the will and I attach formal documentation (proof) of this.
- o I have a claim arising from the patient's death and wish to access information relevant to my claim. The claim is regarding: (please supply your reasons below)

  ……...

Please state the REASON for your request for medical records:

……...

SECTION 4 – Details of Medical Record Request

Please let us know below what TYPE of access to the medical record are you requesting:

Tick	Type of Information Requested	Time Scale	
	Test results	From:	To:
	Vaccination history	From:	To:
	Medication history	From:	To:
	GP Consultations	From:	To:
	Nurse Consultations	From:	To:
	Letters received and referral information	From:	To:
	Other (please specify)	From:	To:
	Full print out of my/the patient's newer medical record held on the computer		
	Full photocopy of my/the patient's older (paper) medical record, which are filed in a secure shelving unit at the practice.		
	OR I do not need a print out, I would like to access my computer medical record ONLINE. I have already spoken to the receptionist and arranged for an account to be set up. I am aware that my online medical record will show me the read coded entries only.		

I understand that:

- I have provided proof of ID to reception and copies have been taken to go with this form. I am aware this is a standard requirement for all access to medical records requests.
- A fee will not be charged for any printed copies.
- The Medical Records Administrator will telephone me to confirm receipt of form received.
- My request will be actioned within **30 calendar days** of receipt of this form and receipt of the relevant documentation.
- Proof of identification will be required again upon collection of any printed copies.

Signed: …… Date: ……

FOR OFFICE USE ONLY: Revised 21.02.22/JU – Review due Feb 2023

	Date	Your initial
PART ONE: Initial of staff member who received form at reception and confirm ID has been checked		
PART TWO Date form was received by Medical Records Administrator		
Scan form into patient's medical record, code in new journal and update patient phone number in medical record if different		
Telephone confirmation made to patient/person making the request. Additional information to be asked, if needed, and confirm when 30 days will expire.		
30 DAYS WILL EXPIRE ON		
Third party documents received, checked & copied		
Code in new journal when request completed. **Remember** ID will be required upon collection of any printed copies. Copies must not be put in collection box in reception.		