WILLOWFIELD SURGERY

Data Subject Access Request/Access to Health Records – 3RD Party

Personal information collected from you by this form, is required to enable your request to be processed, this personal information will only be used in connection with the processing of this Subject Access Request/Access to Health Records
Charges Payable: In accordance with legislation no fee will be charged for your request, unless the request is manifestly unfounded or excessive, particularly if it is repetitive. We will then contact you with details of our 'reasonable administrative charges' in order to comply with your request.

Section 1: Patient details – Please complete in block capitals (*Code: 9NdR.00 Unable to consent to information sharing or 9NdL.00 Lacks capacity to give consent (Mental Capacity Act 2005)*	
Surname:	**Date of Birth:**
Forename(s):	
Any former names (if applicable)	
Current Address: **Full Postcode:**	
NHS number (if known)	
Section 2: Details and declaration of applicant *(Code: 9N32.00 Third Party encounter)*	
Surname:	**Forename(s)**

Address:

Full Postcode:

Daytime telephone number _____

Mobile number _____

I give permission for Willowfield Surgery to contact me on the above number/s and leave a voicemail if I am not available at the time. YES NO

Signature: _____

Relationship with individual who's records you have requested:

Section 2: Record Requested

By completing this form, I am making a request under the General Data Protection Regulation (GDPR) for information held about the individual named in section one by the surgery that I am eligible to receive. I understand that the whole of their medical record or records held between specific dates requested including correspondence, test results and details of every consultation will be made available to me to collect from Willowfield Surgery.

The reason for my request is *(continue on another page if necessary)*	
Please provide me with a copy of all the named persons records held	YES /NO
Please provide me with a copy of the named person's records held between these specific dates	From To

Please provide me with a copy of the named person's records relating to the incident specified below:	
Please provide me with a copy of the named person's records relating to the condition specified below:	

Section 3: Details and declaration of applicant

By signing below, I indicate that I am the individual requesting these records and that the information given be me is correct to the best of my knowledge. I understand that all records must be collected in person from Willowfield Surgery. I understand I must provide the surgery with photographic ID in order for them to release the requested medical records to me.

I understand the practice team may need to contact me for further identifying information before responding to my request. I warrant that I am the individual named and will fully indemnify Willowfield Surgery for all losses, cost and expenses if I am not.

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 GDPR.

Applicant's signature:

Date:

Section 5: Collection of requested records

I confirm I have collected a copy of _____ medical records as requested. I take full responsibility for the safe keeping of the documents received from the surgery once I have signed for them and taken them off the Practice premises.

Applicant's signature: _____ Date: _____

Please tick

□ Proof of identity (*see list – copies to be attached to this form)*

□ Certified copy of court order appointing me to manage the patient's affairs

□ I have full parental responsibility for the patient and the patient is under the age of 18 and

(a) has consented to my making this request *(Code 9Ndi.00 Consent given)* or

(b) is incapable of understanding the request(delete as appropriate)

□ I am acting in loco parentis and the patient is incapable of understanding the request

□ I am the deceased person's Personal Representative and attach confirmation of my appointment(Grant of Probate/Letters of Administration)

□ I have written, and witnessed, consent from the deceased person's Personal Representative and attach Proof of Appointment

□ I have a claim arising from the person's death (please state details on a separate sheet of paper)

I understand that the making of false or misleading statements in order to obtain personal information to which I am not entitled is a criminal offence which could lead to prosecution.

Staff member signature: _____ Date: _____

Please return this form to a member of the Willowfield Surgery reception team. Please allow 28 days for a reply.

Section 6: Proof of Identity/Evidence

Evidence of the patient's and or the patient's representative identity will be required. Please attach copies of the required documentation to this application form. Examples of documentation are:

	Type of applicant	**Type of documentation**
A	Someone applying on behalf of an individual (representative)	• One item showing proof of the patient's identity and one item showing proof of the representative's identity e.g. copy of birth certificate, passport, driving licence, • Plus one copy of a utility bill or medical card etc
B	Person with parental responsibility applying on behalf of a child	• Copy of birth certificate of child • Plus copy of correspondence addressed to person with parental responsibility relating to the patient.
C	Power of Attorney/Agent applying on behalf of an individual	• Copy of a court order authorising Power of Attorney/Agent • Plus proof of the patient's identity (see examples in **'A'** above)