**DR Mc MINN & PARTNERS**
**APPLICATION FORM TO ACCESS MEDICAL RECORDS – JULY 2018**

The 2018 General Data Protection Regulation (GDPR) gives patients the right to access the information held about them in the Practice. All requests for personal information must be in writing and we hope this form will make the process easier for you.

- Under GDPR, this request for personal information is called a ***Subject Access Request (*SAR).**
- For us to release records we need to have proof of ID and assure ourselves of the legitimacy of the request. The Practice is not obliged to comply with a request unless we are provided with evidence of the identity of the requestor.
- There is **no fee** to pay for a first request but subsequent requests **may** carry a charge.
- We will respond to your request within **the statutory calendar month,** upon receipt of valid proof that you have legitimate rights to access the data.

**HOW TO SUBMIT YOUR APPLICATION**

| POST TO THE PRACTICE: | CALL IN PERSON: |
| --- | --- |
| **FAO Practice Manager**<br>McMinn & Partners Practice<br>Bangor Health Centre<br>Newtownards Road<br>**BANGOR**<br>BT20 4LD | Bring your documents in person to the Health Centre |

**HOW TO COMPLETE THE FORM**

**Section 1: Patient Details (data subject)**
This section must be completed for all applicants.

**Section 2: Details of the person acting on behalf of the patient (representative)**
This section should **only** be completed when the application is being submitted on behalf of the patient, **and** on the authority of the patient.

**Section 3: Relationship of requestor to patient**
This section must be completed when application is submitted on behalf of the patient.

**Section 4: Description of the information requested**
This section must be completed by all applicants. You need to specify the records/information you wish to access, providing as much details as possible. If we require further details about the information that you request, we will contact you.

**Section 5: Declaration**
This section must be completed by all applicants and is divided in 2 parts.
- **Part A** must be completed by the patient or legal parent/guardian.
- **Part B** should be completed when the applicant has been provided with authority by the patient—for example, if the request is being submitted by a solicitor.

**Section 6: Supporting documents and identification**
Supporting identification documents must be provided for your request to be processed.

***If you need help please contact Mrs Anne O'Mahony, Practice Manager at 028 91 515300***

**SUBJECT ACCESS REQUEST FORM**

Please complete the application form in **BLOCK LETTERS**.

| Section 1: Details of the patient (DATA SUBJECT) | | | |
|---|---|---|---|
| Surname | | Title | |
| Forename(s) | | | |
| Former names | | | |
| Date of birth | | | |
| Health & Care Number if known | | Hospital Number if known | |
| Address | | | |
| | | | |
| | | | |
| | Country | | Post Code |
| Telephone | | | |
| Email address | | | |

| Section 2: Details of person acting on behalf of patient (REPRESENTATIVE) | | | |
|---|---|---|---|
| Surname | | Title | |
| Forename(s) | | | |
| Address | | | |
| | | | |
| | | | |
| | Country | | Post Code |
| Telephone | | | |
| Email address | | | |

**Section 3: Your relationship to the patient**

Please tick appropriate box:

☐ I have been asked to act by the patient and attach the patient's written authorisation.

☐ I have full parental responsibility for the patient and the patient is under the age of 18 and has consented to my making this request, or is incapable of understanding the request (delete as appropriate)

☐ I have parental responsibilities for the patient who is a minor under 16 years old

☐ I have been appointed as the Mental Capacity Advocate for this patient and wish to access copies of their records—I have attached confirmation of my appointment.

☐ I have been appointed by a court to manage the affairs of the patient—I have attached confirmation of my appointment

☐ Other—please state

## Section 4: Description of information requested

Please tick the appropriate box to indicate if you wish to access:

***Note: if only part of the record is needed, this protects your privacy and reduces Practice photo-copying costs***

☐ ALL records

☐ Specific records regarding the treatment of a condition/illness (please state below) and the approximate date.

☐ Specific records relating to the incident specified(please state below) and the approximate date:

| Please tick ALL relevant boxes to indicate which types of records you wish to access: | ☐ Computer summary report<br>☐ Records of consultations – please specify dates<br>☐ Scanned Correspondence<br>☐ Referral Letters<br>☐ A&E records<br>☐ Results of Investigations<br>☐ Prescribing Records<br>☐ Paper Record<br>☐ Others |
|---|---|
| Please tick the appropriate box to indicate if you would you like copies of these records or just to view them: | ☐ I would like copies of the records<br><br>☐ I would like to view the records |

## Section 5: Declaration – complete Part A or Part B

**Part A:**

☐ **I am the PATIENT**

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 2018. I understand that it is necessary for the Practice to confirm my identity and it may be necessary to obtain more detailed information to confirm my identity and/or locate the correct information.

Full name (print): ____________________________________________________________

Signed: _______________________________________ Date (print): ___________________

**Part B:**

**☐ I am the patient giving authority to a representative to act on my behalf.**

I hereby give my consent for the below named to make a Subject Access Request (SAR) on my behalf under GDPR 2018 to the Practice.

Full name of patient(print): ___________________________________________________________

Patient Signature: ______________________________________ Date (print): _________________

Full name of representative (print):_____________________________________________________

Relationship to patient (print): ________________________________________________________

Representative Signature: _____________________________ Date (print): _____________________

**You are advised that the making of false or misleading statements in order to obtain confidential medical information to which you are not entitled, is a criminal offence.**

**Additional notes**

Before returning this form, please ensure that you have:

1. signed and dated this form
2. enclosed proof of your identity
3. enclosed documentation to support your request (if applying for another person's records)

**Please note a member of the Reception team will contact you by telephone when the records are ready for collection.**

## Section 6: Supporting documents and identification

**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.**

| | Type of applicant | Type of documentation |
|---|---|---|
| A ☐ | An individual applying for his/her own records | One copy of identity required, e.g. copy of birth certificate, passport, driving licence, **PLUS** one copy of a utility bill or medical card, etc.<br><br>**PROOF OF IDENTITY PROVIDED:**<br><br>**PROOF OF ADDRESS PROVIDED:** |
| B ☐ | 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<br><br>**PROOF OF PATIENT IDENTITY PROVIDED:**<br><br>**PROOF OF REPRESENTATIVE IDENTITY PROVIDED:** |
| C ☐ | Person with parental responsibility applying on behalf of a child | Copy of birth certificate of child & copy of correspondence addressed to person with parental responsibility relating to the patient<br><br>**COPY OF BIRTH CERTIFICATE PROVIDED:**<br><br>**COPY OF CORRESPONDENCE ADDRESS PROVIDED:** |
| D ☐ | 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<br><br>**COPY OF COURT ORDER:**<br><br>**PROOF OF PATIENT IDENTITY PROVIDED:** |