ACCESS TO MEDICAL RECORDS APPLICATION FORM – DYSART SURGERY

(Access to Health Records Act 1990/Data Protection Act 1998)

PLEASE COMPLETE THIS FORM IN **BLOCK LETTERS**

DETAILS OF THE PERSON WHOSE MEDICAL RECORDS ARE REQUESTED (please **PRINT**)

Surname _____

Forename(s) _____

Surname if different at time of attendance _____

Date of birth _____ Hospital Number (if known) _____

Address at time of attendance _____

_____

_____ Postcode _____

Telephone Number _____

Signature _____ Date _____

DETAILS OF APPLICANT, IF OTHER THAN THE PATIENT (please **PRINT**)

Surname _____

Forename(s) _____ Date of birth _____

Address _____

_____

_____ Postcode _____

Telephone Number _____ Relationship to patient _____

Signature _____ Date _____

SECTION OF RECORD TO BE COPIES/VIEWED (please circle appropriate response)

DO YOU REQUIRE A COPY OF ALL YOUR MEDICAL RECORDS? YES / NO

IF NO, STATE WHICH PART:

DO YOU REQUIRE THE COPIES TO BE SENT TO YOU? YES / NO

DO YOU WISH TO COLLECT THE COPIES? YES / NO

PLEASE STATE REASON FOR APPLICATION (optional) _____

_____

_____

NOTE: Please supply the following documents when you submit this form:

IF YOU ARE REQUESTING COPIES OF YOUR OWN MEDICAL RECORDS

☐ A copy of your Drivers Licence or Passport

IF YOU ARE REQUESTING A COPY OF ANOTHER PERSON'S MEDICAL RECORDS

1. Another Adult Patient:

☐ Proof of your identity as above
☐ A letter of authorisation from the patient

2. A Child:

☐ Proof of your identity as above
☐ A copy of the child's birth certificate; and
☐ In cases where the child is capable of giving consent themselves, a letter from the child authorising the application

3. A Deceased Patient:

☐ Proof of your identity as above;
☐ A copy of the death certificate
☐ A copy of the Grant of Probate, if available, naming you as their representative or executor.

In absence of the Grant or Probate, or if you are not the representative or executor of the deceased, but still wish to access the records, please provide a letter explaining your reasons for the application and a copy of the death certificate.

DECLARATION

I declare that the information given by me is correct to the best of my knowledge and that (please tick as appropriate):

☐ I am the patient
☐ I have been asked to act by the patient and attach the patient's written authorisation
☐ I am acting in loco parentis and confirm either that the child is incapable of giving consent to the release of their records or that the child is capable of giving consent to the release of their records and enclose the child's written authorisation
☐ I am the deceased patient's Next of Kin / Executor
☐ I have read the information leaflet 'How to Access Medical Records' and am aware of the charges for copying the Medical Records
☐ I understand that the Practice is not liable if I misplace or lose the copied records
☐ I have provided the following information as requested:

PLEASE TICK ALL RELEVANT BOXES

☐ Copy of Driving Licence ☐ Copy of Passport ☐ Copy of Child's Birth Certificate
☐ Letter of Authorisation from patient ☐ Copy of Grant of Probate

Please return the completed form to the:

Dysart Surgery, 13 Ravensbourne Road, Bromley. BR1 1HN

SECTION TO BE COMPLETED BY DOCTOR and MEDICAL RECORDS STAFF

Name of Consultant/Doctor authorising access (please PRINT): _____

Signature: _____ Date: _____

Medical Records staff confirming relevant document received (please Print): _____

Signature: _____ Date: _____