NETTLEHAM MEDICAL PRACTICE

APPLICATION FOR ACCESS TO HEALTH RECORDS

Details of the Record to Access:

Patient Surname:	NHS Number:
Forename(s):	Address:
Date of Birth:	
Telephone Number:	
Email Address:	

Details of the person who wishes to access the records, if different to above:

Surname:	Address:
Forename(s):	
Telephone Number:	
Email Address:	Relationship to Patient:

How would you prefer to receive the records? *Please tick*

Online Access ☐	Email ☐	Disc/USB ☐
Printed ☐	Other *(please specify):*	

Declaration – I declare that the information given to me is correct to the best of my knowledge and that I am entitled to apply for the health record referred to above under the terms of the General Data Protection Regulations 2018.

Please tick as applicable:

- 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 the patient is under the age of 16 (and is incapable of understanding the request) (has consented to my making this request) and enclose written confirmation ☐
- I am the deceased patients personal representative and attach confirmation of my appointment ☐
- I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that _____ ☐

Signed: _____ Date: _____

Certification: I certify that I am (name) _____

Of (address) _____

And that I have been known to the applicant for ___ years as an employee/client/patient/personal friend and have witnessed the applicant sign this form.

Signed: _____ Date: _____

……

Official Use Only

Form received/not appropriate Signed: _____ Date: _____

Health Professional Advising (Name): _____