Helix Medical Centre
Herts & Essex Hospital, Cavell Drive, Haymeads Lane
Bishops Stortford, Hertfordshire, CM23 5JH.
Tel: 01279 594450

# APPLICATION FORM FOR ACCESS TO HEALTH RECORDS
# in accordance with the General Data Protection Regulation (GDPR)
# DATA SUBJECT ACCESS REQUEST – (DSAR)

This form must be completed in blue or black ink and signed in order for us to process your request.

**Introduction:**
As part of the General Data Protection Regulations (GDPR), patients have a right to access their health records. You can have access to your records by one of the following methods:

- **Online Access** - We advise this option as you can simply log-in online and view your up-to-date record at any time you wish along with sharing it with whoever you wish to. By having online access to your record you can also take advantage of being able to request your repeat medication and book / cancel appointments too.
- **Emailed report** – we can securely email your health record to you. This enables you to view your record and is also an eco-friendly and cost-effective method.
- **Printed report** – We can print your health record for you. This option however is not eco-friendly and is also costly to the practice. We therefore request that you choose one of the other options above where possible.

**SECTION 1**

**Patient Details**

| | |
|---|---|
| Surname: | First name: |
| Date of birth: | Email address: |
| Address:<br><br>Postcode: | |
| Home Tel: | Mobile: |
| NHS Number (if known): | |

**Applicant Details (if different from above)**

| | |
|---|---|
| Name: | Email address: |
| Address:<br><br>Postcode: | |
| Home Tel: | Mobile: |
| Organisation: | |

**For all applications please complete section 1 and refer to section 5 for appropriate ID**

**For online access please complete sections 1, 2 and 4**
**For emailed or printed records please complete sections 1, 3 and 4**

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| **For use of Practice Reception only on receipt of completed application:** | |
|---|---|
| Patient NHS number: | Date stamp application received: |
| **Identity Verified:** Staff Initials: | Photo I.D. Seen [ ] |

**SECTION 2**

**Request For:**

| □ Online Access | Recommended Option (see introduction above) |
|---|---|
| I wish to have Detailed Coded Access to my Medical Record via 'Online Services' | ❑ |

| **I wish to access my Medical Record online and understand and agree with each statement below (tick):** | |
|---|---|
| I have read and understood the information leaflet provided by the Surgery. | ❑ |
| I will be responsible for the security of the information that I see or download. | ❑ |
| If I choose to share my information with anyone else, this is at my own risk. | ❑ |
| I will contact the Surgery as soon as possible if I suspect that my account has been accessed by someone without my agreement. | ❑ |
| If I see information in my record that is not about me or is inaccurate, I will contact the Surgery. | ❑ |
| I understand the Surgery will inform me of the outcome of my application once this has been assessed by the GP. | ❑ |
| Signature: | Date: |
| **Photographic I.D. is to be provided to the Reception Team at the time of returning your completed application (see section 5a for guidance)** | |

| **For Completion by Authorising Clinician only:** | |
|---|---|
| Authorising Clinician Signature: | Date: |
| ***Access to Patients Detailed Coded Record:*** Approved / Declined (please circle)<br>**If approved - Level of Proxy Access:**<br>*All coded content authorised:* [ ] or *coded content authorised from* (date): | |
| *Pass form to management - access to be applied in Sys1 & text or letter confirmation sent to patient* | Date: |
| Reception to scan completed form to patient record once above items actioned, then shred confidentially | Date:<br>Staff Initials: |

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## SECTION 3

### Request For:

| | |
|---|---|
| □ Emailed Record | Recommended |
| □ Printed Record | Not Recommended (see introduction above) |

The more specific you can be, the easier it is for us to quickly provide you with the records requested. Record in respect of treatment for: (e.g. leg injury following a car accident)

| | |
|---|---|
| **Please provide me with a copy of all records held** | |
| **Please provide me with a copy of records between the dates specified:** | |
| **Please provide me with a copy of records relating to the incident specified:** | |
| **Please provide me with a copy of records relating to the condition specified:** | |

**Can we refuse to comply with a request?**
We can refuse to comply with a subject access request if it is manifestly unfounded or excessive, taking into account whether the request is repetitive in nature. If we consider that a request is manifestly unfounded or excessive, we can:

- Request a "reasonable fee" to with the request; or
- Refuse to deal with the request.

In either circumstance we will justify our decision. If we decided to charge a fee we will contact you promptly and inform you of the likely costs. We do not need to comply with the request until the fee is received.

**How long do we have to comply?**
We will act on the subject access request without undue delay and at the latest within one month of receipt. We will calculate the time limit from the day after we receive the request (whether the day is a working day or not) until the corresponding calendar date in the next month.

**Can we extend the time for a response?**
We can extend the time to respond by a further two months if the request is complex or we have received a number of requests from the patient. We will let you know within one month of receiving your request and explain why the extension is necessary.

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**SECTION 4**

**Declaration**

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.

Please tick:

☐ I am the patient

☐ 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:
(a) has consented to my making this request, or
(b) is incapable of understanding the request (delete as appropriate)

☐ I have been appointed by the court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so

☐ 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 below)

Signature of applicant: ..... Date: ……..

**You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.**

You will be provided with this information, along with an additional privacy information notice in order to comply with the General Data Protection Regulation (GDPR).

You are responsible for the confidentiality and safeguarding of the copies of your medical records which will be provided for you. This practice accepts no responsibility for the copies once they leave the premises.

By signing this form, you are accepting full responsibility for the security and confidentiality of the copies of your medical records.

Patient name: …….

Patient NHS number: ……

Signature of applicant: ..... Date: ……..

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## SECTION 5: PROOF OF IDENTITY

Please indicate how proof of ID has been confirmed. Please select 'A' or 'B':

| | Method in which identity is confirmed | Option taken | Documents attached |
|---|---|---|---|
| A | Attached copies of documents as noted in section 5A below | Yes / No | If Yes, please indicate here which documents have been attached |
| B | Countersignature (section 5B). This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided) | Yes / No | Please indicate reason why this section was completed |

### 5A – 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 required documentation are:**

| | 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. |
| **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 (see examples in '**A'** above) |
| **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 |
| **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 (see examples in '**A'** above) |

### 5B – Countersignature

**This section is to be completed by someone (other than a member of your family) who can vouch for your identity. <u>This section may be completed if 4A cannot be fulfilled.</u>**

I (insert full name).....

Certify that the applicant (insert name).....

Has been known to me personally as ..... for .....years
(Insert in what capacity, e.g. employee, client, patient, relative etc.)

and that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed .....Date .....

Name ..... Profession. .....

Address .....

.....

Daytime telephone number .....

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**Additional notes**

Before returning this form, please ensure that you have:

a) completed all sections relevant to your application

b) signed and dated this form

c) enclosed proof of your identity or alternatively confirmed your identity by a counter signature

d) enclosed documentation to support your request (if applying for another person's records)

Incomplete applications will be returned; therefore, please ensure you have provided the correct documentation before returning the form.