**Three Harbours Medical Group**

**Access to Health Records & Requests for Other Personal Information**

**GDPR 2018, for living patients**

**ACCESS TO HEALTH RECORDS ACT 1990, for deceased patients**

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| **Section 1 – Patient Details** |
| Please make sure you use your formal name in this section |
| Mr Mrs Ms Dr | Other |  | Surname |  |
| First Name |  |
| Second Name |  | Other Initials |  |
| Address  |  |
|  |  |
|  |  |
| Post Code |  | Telephone Number |  |
| Date of Birth |  |
| We will contact you on the above number to let you know when the records are ready to collect. Are you happy for us to leave a message at this number? (please tick) | Yes | No |
| If the telephone number is a mobile phone, would you like us to update your records so that you receive text message appointment reminder and other health messages, communications and reminders from us? (please tick) | Yes | No |
| **Section 2 – Information you require – please select from the following options** |
| 1. | Please provide me with copies of my medical records for the following period |
| From: |  | To: |  |
| 2. | Please provide me with a print-out of my medical records that are held on computer | Tick: |  |
| 3. | Please provide me with copies of my entire medical records from my date of birth to date (to include any paper records as well as those held on computer) | Tick: |  |
| 4. | Please provide me with my medical records regarding a specific condition (detail below) | Tick: |  |
| 5. | I would like to view my medical record | Tick: |  |
| 6. | Other – please specify below | Tick: |  |
| Further Information |
|  |

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| **Section 3 – Declaration** |
| 1. | I am the patient. The practice may require to verify your ID. | Tick: |  |
| 2. | I am acting on behalf of the patient and the patient has provided written consent (attached). The practice may be required to verify your ID. | Tick: |  |
| 3. | I am the deceased patient’s representative and attach confirmation of my status. | Tick: |  |
| 4. | I have Welfare Power of Attorney for this patient and attach relevant documentation. | Tick: |  |
| 5. | I have been appointed by the court to manage the affairs of the patient and attach relevant documentation. | Tick: |  |
| 6. | Other, please specify:.................................................................................................................................................................... | Tick: |  |
| **Section** **4 – Signature** |
| Print Name |  |
| Signed |  | Date |  |
| Address (if different from above) |  |
| Telephone Number (if different from above) |  |

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| **For Practice Use ONLY** |
| **Action** | Signed | Date |
| Identity verifiedPlease list documents seen | 1. | 2. |
| **Data Extracted** |  |  |
| **Patient advised ready to collect** |  |  |