**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 verified  Please list documents seen | 1. | 2. |
| **Data Extracted** |  |  |
| **Patient advised ready to collect** |  |  |