Access to Medical Records Request - Eastfield

**Details of the Record to be accessed:**

|  |  |
| --- | --- |
| Patient Surname | NHS Number |
| Forename(s) | Address |
| Date of Birth |

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

|  |  |
| --- | --- |
| Surname |  |
| Forename(s) |  |
| Address |  |
| Telephone Number |  |
| Relationship to Patient |  |

Tick whichever of the following statements apply.

* 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 age sixteen, and is incapable of understanding the request / has consented to me making this request.

(\*delete as appropriate).

* I have a claim arising from the patient’s death and wish to access information relevant to my claim on the grounds that (please supply your reasons below).

**Applicant signature..................……………………..........Date………………………..**

**Patient to complete**

**(Please tick as appropriate)**

|  |  |
| --- | --- |
| I am applying for access to view my records online only |  |
| I am applying for paper copies of my medical record |  |
| I have instructed someone else to apply on my behalf |  |

**(Please tick as appropriate)**

|  |  |
| --- | --- |
| I would like a copy of/online access to my entire medical record. |  |
| I would like a copy of/online access to records between specific dates only (please give date range) below |  |
| I would like copy of/online access to records relating to a specific condition / specific incident only (please detail below) |  |

**(Tick to state that you understand and agree with each of the following statements):**

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice |  |
| 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 practice 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 practice as soon as possible |  |

Note: There is no fee to have access to Medical Records unless the request is excessive.

(For use of Eastfield Medical Centre Staff Only)

|  |  |
| --- | --- |
| Patient NHS Number: | Patient EMIS Number: |
| Date Received: | Method used to identify patient: |
| Identity verified by: |
| Assigned GP: |
| Level of record access enabled: | Any Additional Notes |
| Date Access to Medical Records Granted: | |