

# WHITEHALL MEDICAL PRACTICE

## REQUEST FOR ACCESS TO HEALTH RECORDS

### APPLICATION FORM

#### WARNING

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

#### 1. PATIENT DETAILS

Surname:

Forename (s):

Date of Birth:

NHS Number (if known):

Name of General Practitioner:

If the patient is deceased please provide date of death:

#### 2. APPLICANT DETAILS (if different from above)

Surname:

Forename (s):

Address:

Daytime Contact Number:

Relationship to the Data Subject (patient)

Parent or Guardian

Agent (specify).....

Other.....

Please attach a copy of the authority to act on behalf of the Data Subject

#### 3. RECORDS REQUESTED

Please indicate which records you require to enable us to locate the information within the specified timescale.

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## 4. DECLARATION

I declare that the information provided is correct to the best of my knowledge and that I am entitled to apply for access to the health record referred to above under the terms of the Data Protection Act 1998 and/or Access to Health Records Act 1990.

Please tick

Please tick below whichever is the most appropriate:

I am the patient;

I have been asked to act on behalf of the patient and attach the patient's written authorisation;

I am the deceased patient's 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 (please complete)

.....

Signature.....Date:.....

Address:

.....

.....

Daytime telephone number (in case of query).....

Please note:

- If a third party is applying for access, then written confirmation from the patient, or in the case of the deceased their next of kin or personal representative, should be enclosed;
- Documentary evidence to support the request should be enclosed.

## 5. COSTS

I enclose a minimum fee of £10.00, which I understand is required to be paid initially.

Please note that if your request results in a large number of photocopies being required there may be additional costs levied up to a maximum of £50.00. These charges are to cover photocopying and postage and no action will be taken until the appropriate fee has been received.

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Payment can be made by:

- Cash
- Cheque made payable to Whitehall Medical Practice
- Visa – Mastercard – Visa Debit – Maestro - Amex

## 5. CERTIFICATION

Witness Statement:

I (insert full name) ..... certify that the  
Applicant (insert name) ..... has been known  
Personally to me as a (insert in what capacity, e.g. employee, client, patient etc)  
..... for ..... Years and that I have  
witnessed the signing of the above declaration.

(Please note that it is not acceptable for a spouse or relative to sign the form).

**IMPORTANT: Please ensure that you have enclosed:**

- This completed/signed application form;
- Your payment in an amount of £10.00 minimum fee;
- Proof of your identity. Photocopies (not originals) of either:
  - Passport
  - Photo card Driving Licence
  - Birth Certificate
- If you are applying for records on behalf of a patient you will need to provide proof of your identity (as above) and you must also include the patient's written authorisation for you to have access to their records;
- If you are applying for records of a deceased individual you must include proof of your own identity together with proof of court appointment as personal representative.