**ACCESS TO MEDICAL RECORDS AND DATA PROTECTION**

**PATIENT INFORMATION LEAFLET**

**Your Rights**

You can ask your doctor, dentist or any other health care professional who has been treating you to see the records that he or she has made about your health. The Data Protection Act allows you to access your medical records.

**Who Can Apply to see the Records?**

You can make your own application to see your records or you can give your written permission for someone else to look at your records for you. A parent or guardian, a patient representative or a person appointed by the court can apply.

Examples:

* A parent may see a child’s records if the child is under 16 years of age. However, a child aged 12 or above is generally considered mature enough to understand what a subject access request is and should therefore be asked to provide their consent to allow their parents to make the request for them. You may be prevented from obtaining access to the records if a health professional considers that the information requested would not be in the child’s best interest.
* You can apply to see the record of a person who has died (The deceased person’s representative).

Examples of when health records will not be released:

* A record holder can decide not to let you see your records if they feel the records may cause serious harm to your physical or mental health, or that of any other individual.
* If in the option of the record holder, giving access would identify someone else who does not wish information about then held in the record to be disclosed. This does not include your doctors or health care professional.

**How to apply for access to records held by the Practice.**

* Fill out our “Application to Access Med Records Consent Form” which is available at reception.
* Should you wish to see and view the original records; a time will be arranged for you to meet with a member of the Practice staff or your GP.
* If this is not possible you can seek advice from the practice by contacting us in person or by telephone on the relevant number below.
* You can make your application in other formats, please speak to the practice to discuss further.
* Citizen’s Advice Patient Advisory Service may be able to assist with your request.

There is no fee payable; access is free of charge unless the request is excessive or it is a second request.

**Timescales for Response**

The Practice will aim to respond to requests for access:

* Within 1 calendar month for health records relating to living patients
* Within 21 days for health records of deceased patients

**Proof of Identity**

You have a right to expect that the holders of your health records will maintain confidentiality. The Practice must be satisfied that any person who makes an application is entitled to do so. This means that you may be asked to prove your identity. Other enquires may also be made to check you have a right to access the records. For this purpose, it is essential that your application is countersigned appropriately.

For other information, reports letter and/or certificates please speak to reception who will give you further information, including any fees that may be charged for these services.

**SUBJECT ACCESS REQUEST (SAR) FOR PATIENT MEDICAL RECORDS**

**Patient Authority Consent Form**

**Access to Medical Records under the General Data Protection Regulations (GDPR)**

Patient’s authority for release of medical records (Manual or Computerised Medical Records)

To: Old Irvine Road Surgery, 4/6 Old Irvine Road, Kilmarnock KA1 2BD

Section 1 – Your Details

1. Full name (including former name(s):

**…**………………………………………………………………………………………..

2. Former name(s) ……………………………………………………….

3. Date of Birth: ………………………………………….……………

4. NHS/CHI Number (**if known**) ……………………………………………………….

5. Current Address: ………………………………………………………

………………………………………………………

5. Tel or Mobile number (including area code) ………………………………………......................

6. Former Address (if applicable) ……………………………………………………….

(Use separate sheet if necessary)

……………………………………………………….

……………………………………………………….

7**.** 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 delete as appropriate) **YES/NO**

8. Details of person who will be collecting Medial Records: **Name** ……………………………………

**Address** ……………………………………………………… **DOB** …………………………………….

**IMPORTANT INFORMATION**

Under GDPR you do not have to give a reason for applying for access to your medical records. However, to help us save time and resources, **if you wish,** it would be helpful if you could provide details, on the next page, informing us of periods and parts of your medical records you require, along with details which you may feel have relevance i.e. consultant name and location etc. **See next page**:**­­­­­­­­­­­­­­­­­­­­­­­­**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section 2 – Information you require – please complete 1,2,3 or 4 | | | | | | | | | |
| 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 use this space below to inform us of certain periods and parts of your health records you may require. This may include specific dates, consultant name and location, and parts of the records you require i.e. written diagnosis and reports.**  **Below is an example of using the space provided.**  *Example*  *1st March 1993-31st March 1995 – all my GP notes and the consultant reports to my GP concerning back pain within this period.* | | | | | | | | |
| Section 3 – Signature | | | | | | | | | |
| Signed | |  | | | | Date |  | | |
| *Please present or give copies of ID when handing in or emailing the form.*  *(eg passport, photo driving licence or utility bill)* | | | | | | | | | |

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