

**SUBJECT ACCESS REQUEST – COPIES OF MEDICAL RECORDS (PRACTICE PROCESSES)**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Received |  | Date Due to be Completed (28 days) |  |

**PATIENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forenames |  |
| Date of Birth |  | EMIS No. |  |
| Address |  | | |
| Email |  | | |

**REQUESTOR**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name |  | | | |
| Address |  | | | |
| Email |  | | | |
| **How was the request made?** If request received electronically, information should be provided in a commonly used electronic format | | | | |
| In Writing 🞎 | | Email 🞎 | Verbally 🞎 | Other 🞎 |

**ACCESS DETAILS**

|  |  |
| --- | --- |
| **Access under General Data Protection Regulations 2016/679** (Free) |  |
| **Access to Medical Reports (AMRA) 1990** (Chargeable) i.e. reports for employment and insurance purposes includes cover for accident claims, insured negligence, mortgage and life insurance. Anything covered by an insurance contract to support actual or potential insured claim then AMRA applies.  If the requestor letter does not specify precise purpose of request contact requestor to clarify via standard letter  Response | Yes 🞎 No 🞎  Date Sent  Date |

**DETAILS OF REQUEST**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Entire Medical Records | Yes 🞎 No 🞎 | | | |
| Dates | From |  | To |  |

**VERIFICATION OF AUTHORITY/PATIENT CONSENT**

|  |  |
| --- | --- |
| **Requestor’s Identity Confirmed** | Yes 🞎 No 🞎 |
| **Requestor’s Legal Authority Confirmed** | Yes 🞎 No 🞎 |
| **Patient’s Identity Verified** | Yes 🞎 No 🞎 |
| **If Patient does not have capacity – verify:** | |
| **Enduring Power of Attorney** | Yes 🞎 No 🞎 |
| **Lasting Power of Attorney for Health & Welfare** | Yes 🞎 No 🞎 |
| **Court Appointed Deputy** | Yes 🞎 No 🞎 |

**CONTACT WITH PATIENT**

|  |  |
| --- | --- |
| **Date of Patient Contact** |  |
| **Need to inform the patient ‘***It is my duty to discuss the recent request made by …..with you and to advise you what information will be provided, that we hold for you on your computer records and in your paper records. It is your choice to decide the amount of information we provide to the requestor – this can be your entire medical records or from a specific date’* | |
| **Discussed type of information held by the Practice which can include:** | |
| Demographic Date | Yes 🞎 No 🞎 |
| Diagnoses and Investigation Results | Yes 🞎 No 🞎 |
| Procedural and consultation information recorded by Practice and Ancillary colleagues, eg District Nurse, Health Visitor | Yes 🞎 No 🞎 |
| Immunisations and medications | Yes 🞎 No 🞎 |

|  |  |
| --- | --- |
| All Letters | Yes 🞎 No 🞎 |
| Sensitive Information – Sexual Health and mental health access | Yes 🞎 No 🞎 |
| All third party information will be removed i.e. any references to named individuals – spouses, children etc. | Yes 🞎 No 🞎 |
| Patient Confirms Requestors Request | Yes 🞎 No 🞎 |
| If No – details of patient’s new request | Yes 🞎 No 🞎 |

**CONFIDENTIAL THIRD PARTY INFORMATION REMOVED/REDACTED**

|  |  |
| --- | --- |
| Yes 🞎 | Details of information removed - |
| No 🞎 |  |

**GP CONFIRMATION FOR RELEASE OF MEDICAL RECORDS**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Clinician | | | |
| Request Authorised | | | Yes 🞎 No 🞎 |
| Patient Details Validated | | | Yes 🞎 No 🞎 |
| Copies of medical Records validated for third part information, sensitive information and redaction complete | | | Yes 🞎 No 🞎 |
| Request authorized for release | | | Yes 🞎 No 🞎 |
| Clinician Signature |  | Date |  |

**PATIENT NOTIFIED FOR COLLECTION**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Patient Notified |  | Notified By |  |
| No later than 30 days from the date requested | | | |

**COLLECTION OF COPIES OF MEDICAL RECORDS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I confirm receipt of copies of the medical records regarding the above-named and understand that I am now responsible for keeping them and the information contained therein safe and secure. If I believe or suspect that the information has been accessed without my agreement, I will contact the practice as soon as possible to record this on my records. | | | | |
| **Name of Staff member handing over Records** |  | | **Signature** |  |
|  |  | |  |  |
| **Person Receiving Records** |  | | **Signature** |  |
| **Date** |  | | **Time** |  |
|  |  | |  |  |
| **Type of Identity – ID1** |  | | **Confirmed By** |  |
| **Date of Completed Request** | |  | | |

Once completed, the patients can collect. We do not post out. If additional copies are required, these will be charged for. **ID must be shown at the time of collection.**

Please ensure that any information is put into a sealed plastic envelope before handing over

Please pass form for scanning into notes when completed. Once scanned, form can be destroyed.

|  |  |  |
| --- | --- | --- |
| Whitchurch Surgery  49 Oving Road, Whitchurch, HP22 4JF  Tel: 01296 641203 | Wing Surgery  46 Stewkley Road, Wing, LU7 0NE  Tel: 01296 688949 | Norden House Surgery  Avenue Road, Winslow, MK18 3DW  Tel: 01296 713434 |