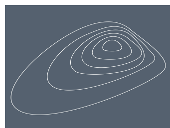 **Skene Medical Group**

IN CONFIDENCE

DATA PROTECTION ACT 1998
REQUEST FOR ACCESS TO PATIENT INFORMATION

You are advised that the making of false or misleading statements in order to obtain access to personal information to which you are not entitled is a criminal offence

Access to personal records is an important matter. The release of certain data may in certain circumstances cause distress. You may wish to consult an appropriate professional before completing your application**.**

Please read the attached guidance notes before completing. Please note, we deal with applications for GP RECORDS only. If you require Hospital Records, you must apply directly to NHS Grampian.

PLEASE COMPLETE IN BLOCK CAPITALS AND BLACK INK

SECTION 1: PATIENT DETAILS

Surname:	**Forename(s):**	
Address:	**Date of Birth:**	**Sex:**
	Telephone No. Home:	
Postcode:	**Telephone No. Mobile:**	
	Email:	
CHI/Patient Number (if known)		

SECTION 2: INFORMATION REQUESTED

Please provide as much information as possible. Give full details of all the treatment periods you are interested in e.g. a specific timeframe or are you requesting all your records. Please give as much detail below.

Additional Information:

SECTION 3: TYPE OF RECORDS REQUESTED

Please specify your preference by placing Y or N in the appropriate sections - please discuss with the Practice Manager if you are unsure.

	Yes(Y)/No(N)	**CHARGE**
View original records only (by appointment)	☐	**£10.00**
Photocopy or Printout only of Electronic GP consultations or part thereof	☐	**£10.00**
Photocopy or Printout of Electronic GP Consultations + all Hospital letters etc.	☐	**£50.00**
Photocopy or Printout of Electronic and Paper GP Consultations + all Hospital letters etc.	☐	**£50.00**

The appropriate fee must accompany this application or the request will not be processed.
Cheques should be made payable to Skene Medical Group

IN CONFIDENCE

SECTION 4: DECLARATION This section of the form must be signed in the presence of the person who countersigns your application.

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the record referred to above under the terms of the Data Protection Act 1998.

☐ I am the patient

☐ I am the patient's personal representative (please provide proof of authority)

☐ I have been asked to act by the patient who has completed the authorisation section.(Section 6)

☐ I am the parent/guardian of a patient is under 16 years old who has completed the authorisation section (Section 6)

☐ I am the parent/guardian of a patient is under 16 years old who is unable to understand the request.(Section 7)

SECTION 5: APPLICANT DETAILS

Applicants Name (Please Print):	
Address (if different from over) inc Postcode:	
Signature of Applicant:	Date:

SECTION 6: AUTHORISATION

I hereby authorise Skene Medical Group to release the Personal Data requested relating to me to

(Enter the name of the person acting on your behalf)…………………………………………………..
Address:………………………………………………………………………………………………………
……
……

Contact telephone number:…………………………………………………………………………

To whom I have given consent to act on my behalf.

Signature of Patient ____ Date_________

SECTION 7: COUNTERSIGNATURE/PROOF OF IDENTITY

COUNTERSIGNATURE (see Notes – Section 7)

To be completed by the person required to confirm the applicants identity, it is essential that your application should be countersigned by any one of the following: a Member of Parliament, Justice of the Peace, Minister of Religion, a professionally qualified person (for example, Doctor, Lawyer, Engineer, Teacher), Bank Officer, Established Civil Servant, Police Officer or a person of similar standing who has known you personally.
A relative should not countersign.

I certify that I am [Name] ____

Of [Address] ____

____

____

Telephone Number ____

Profession ____

and that I have known the applicant named above for _______ years and have witnessed the applicant sign this form.

Signed ____________________________ Date ______________________________

SECTION 8: PROOF OF IDENTITY

Alternatively, please provide suitable clear photocopies of proof of identity (see Notes - Section 8)

OFFICIAL USE ONLY			
CRN/CHI Number			
Countersignature Checked			
ID checked			
Fee Paid			

The correct payment must accompany this form before the Access to Medical Records Request will be processed

Data Protection Act allows for 40 days on receipt of request and appropriate fee to completion of the request

PLEASE REFER TO GUIDANCE