ACCESS TO MEDICAL RECORDS
APPLICATION FORM

Please fill in this application form using BLOCK CAPITALS and black ink.

Section 1: Personal Details of the person this access request is about

Last name:		**First name:**	
Address & Postcode:			
Date of Birth:			
Home Phone:			
Mobile Phone :			
CHI (community health index) if known			

Section 2: Information you want to access

Give details in the box below of the records or information you want to access.

Please put an X in the appropriate box to show which information you want and the format you would like the information in (discuss this with staff if you are not sure).

Details	**Manual (paper)**	**Computerised**
See original records only	☐	☐
Ask for a copy	☐	☐
See records and receive a copy	☐	☐

Section 3: Who is Applying For Access to the Information

Please tick the relevant box that applies:

- I am the person named in Section 1 ☐ → **Go to Section 6**
- I have been asked to act on behalf of the person named in Section 1, and that person has filled in Section 5. ☐ → **Go to Section 4**
- I am the parent or guardian of the person named in Section 1, and that person is under 16 years old and has a general understanding of what it means to request access to personal information (in Scotland, the law presumes this for children aged 12 years and above), and they have filled in Section 5 ☐ → **Go to Section 4**
- I am the parent or guardian of the person named in Section 1, and that person is under 16 years old and is not able to understand the request ☐ → **Go to Section 6**
- I have been appointed by the court to manage the affairs of the person named in Section 1 and enclose proof of this (**please provide a certified copy**) ☐ → **Go to Section 7**
- I hold a welfare power of attorney in relation to the person named in Section 1 and enclose proof of this (**please provide a certified copy**) ☐ → **Go to Section 7**

Section 4: Details of the Person Acting on Behalf of Others

You must fill in this section if the person named in section 1 has given you permission to act on their behalf

Name: **(Please print)**	
Address and postcode we should send a reply to:	
Contact phone number:	

→ **Now please complete Section 5**

Section 5: Permission

You must fill in this section if you are the person named in Section 1 and you have given the person named in Section 4 permission to act on your behalf.

I give you, **Whinpark Medical Practice**, permission to give ___________________________ (*enter the name of the person acting on your behalf*) the personal information requested in this form. I have given them permission to act on my behalf.

Signature: _______________________________________ Date: / /

Print Name: _______________________________________

➔ **Now go to Section 6**

Section 6: Identification/Countersignature

Everyone must complete this section UNLESS you are providing:

- A certified copy of a Power of Attorney document
- A certified copy of a Guardianship Order

The information we hold is confidential and we must get proof of your identity and your right to receive any relevant information. There are two ways you can do this, **please place a tick in the relevant box next to your preferred option:**

1 – Provide Two Forms of Identification (ID) ☐

We require proof of identification and current address. The following is a list of documents we will accept

Proof of ID

- Copy of the identification/photographic page from a current passport
- Copy of the identification/photographic section of a current driving licence
- Other forms of photo ID including travel pass, work badge

Proof of Address

- Copy of a recent utility bill or bank statement
- Copy of current rental agreement
- Copy of recent pay slips

Please do not send original documents.
Any financial details can be redacted (blacked out) or removed.

OR

2 - Countersignature ☐

The other way to confirm a person's identity is by providing a countersignature.

You only need to confirm the identity of the person applying, and be a witness when they sign the declaration (Section 7). You do not need to see the rest of the form.

A family member or relative should not be asked to sign.

In some cases, we may ask the person applying for more documents as proof of their identity.

I (write your full name) ____ confirm that

I have known (name of the person applying) ________________________________ for

________ years, and I was present when they signed the declaration.

Signature:		**Date:**	/ /
Full Name:			
Profession (for example teacher)			
Address:			
Postcode:			
Phone Number:			

Section 7: Declaration

You must sign this section, and if providing a countersignature to confirm your ID the person you have named in Section 6 (the counter signatory) must be present when you sign.

Releasing information
Keeping personal information confidential and secure is extremely important to us.

We use recorded delivery to send documents by post. If you choose to collect the information in person please ensure you have arranged a time with a member of staff and bring along two forms of identification with you, including one which has your photograph on (see description in Section 6 detailing what we will accept).

Please note: if a fee is incurred in complying with this request, we will not release information until we have received your payment. (*Please see our information leaflet for more information*)

I confirm that the information I have given is correct and that I am entitled to apply for access under the conditions of General Data Protection Legislation.

Signature: ____

Print Name: ____

Date: / /

Handy Check List

Before returning the form, please make sure the following information has been provided:

Has the form been signed by the patient and or applicant? ☐

Has the form been countersigned or copy ID provided? ☐

Have you provided a phone number to enable us to contact you to discuss your application (if required)? ☐