

# ELLON GROUP PRACTICE



## Access to Health Records & Requests for Other Personal Information

GDPR for living patients  
ACCESS TO HEALTH RECORDS ACT 1990, for deceased patients

### Section 1 - Details of Person Whose Records Are Being Requested

Surname: .....  
Former Surname (if applicable): .....  
First Name(s): .....  
Date of Birth: .....  
Registered Address: .....  
Current Address (If Different From Above):.....  
.....  
Postcode: .....

Daytime Telephone Number: .....

I have received the leaflet "How to Request GP Records & Other Personal Information"

### Section 2 – What Information Is Required?

- A DWP / PIP information summary report only
- A Paper Copy of the Full Record
- To View Your Health Records
- Paper Copy Immunisations Record
- A Paper Copy of Records for Date Range
- From.....To.....
- A Copy Letter or Statement From a GP
- Other (please specify below)

**Section 3**

**Please give full details of what the information will be used for:**

**Section 4**

**Please use the space below for further information you feel is relevant to this application:**

**Section 5 - Declaration –**

I declare that the information given by me in Sections 1-4 herein is correct to the best of my knowledge and that I am entitled to apply for this information.

Please tick appropriate box:

- I am the patient
- I have been appointed by the court to manage the affairs of the patient and attach relevant documentation
- I am acting on behalf of the patient and the patient has completed the authorisation (Section 6)
- I am the deceased patient’s representative and attach confirmation of my status
- I have Welfare Power of Attorney for this patient and attach relevant documentation
- Other, specify.....

Patient or Applicant’s name: .....

Patient or Applicant’s signature.....

Address if different from above.....

Daytime telephone number.....

**Please ignore this section if you are requesting your own health records/personal information**

**Section 6 - Patient's Authorisation**

I authorise Ellon Group Practice to release the information requested

to.....

Whom I have given consent to act on my behalf.

Signature

.....Date.....

**Please return this form to Ellon Group Practice, Schoolhill, ELLON, AB41 9JH or email [gram.ellonadministrator@nhs.scot](mailto:gram.ellonadministrator@nhs.scot)**

*Please be reminded that your I.D. will require to be verified at the Practice prior to the uplift of any provided information.*

**OFFICE USE ONLY**

**SAR Application Received Date:**.....

**GP Reviewed by:** ..... **Date:** .....

**SAR Application Completed Date:** .....

**Confirmation of Identity: I.D. checked / Patient verified**

**Patient ID Verified by:** ..... **Date:** .....