ELLON GROUP PRACTICE

Access to Health Records & Requests for Other Personal Information

GDPR 2018, 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 The Practice Manager, Ellon Group Practice, Schoolhill, ELLON, AB41 9JH

Please be reminded that your I.D. will require to be verified at the Practice.

OFFICE USE ONLY

SAR Application Received Date: ……....

SAR Application Completed Date: …….

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

Patient ID verified by..... Date.....