**ONLINE ACCESS TO FULL MEDICAL RECORDS REQUEST FORM**

**In accordance with the UK General Data Protection Regulation (UK GDPR)**

**Guidance notes – please read before completing this form:**

Patients with online accounts, such as through the NHS App, should already be able to read new entries within their medical records dated from 1st November 2023 and onwards (or from the date of registration with the surgery if registered after 1.11.23) This form applies to past record entries and historic data.

If a child is aged between 13-17 years and has ‘sufficient understanding and intelligence to enable him/her to understand fully what is proposed’ (known as Gillick Competence), then s/he will be deemed competent to request access to their own records or consent to give proxy access to a representative i.e. parent.

**OPTIONS (reason for completing the form)**

* Patients requiring access to their own records **(Sections 1, 2, 7)**
* Representative requesting access to another adults records (proxy access) where the patient **HAS FULL** capacity **(Sections 1, 3a, 3b, 5, 6, 7)**
* Representative requesting access to another adults records (proxy access) where the patient **DOES NOT** have capacity **(Sections 1, 4, 5, 6, 7)**
* Parents requiring access to their child’s records (aged 13-17 years) – Childs signature required where appropriate **(Sections 1, 3a, 3b, 5, 6, 7)**
* Parents requesting access to child’s records (aged 0-12 years) **(sections 1, 3b, 5, 6, 7)**

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Former name** |  |
| **Forename** |  | **Title** |  |
| **Date of birth** |  | **NHS number (if known)** |  |
| **Telephone number** |  | **Postcode:** |  |
| **Address:** |  |

**Section 2: Record requested.**

I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Access to my full medical records | 🞏 |

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the organisation | 🞏 |
| I understand that I will automatically see any new information that is added to my healthcare record. | 🞏 |
| I will be responsible for the security of the information that I see or download | 🞏 |
| If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature** |  | **Date** |  |

**Section 3a: Consent to proxy access to GP Online Services (if patient has capacity)**

* I…………………………………… (name of patient), give permission to my GP practice

to give the following person/people ………………………………………………… proxy

access to the online services as indicated below in Section 5

* I reserve the right to reverse any decision I make in granting proxy access at any time
* I understand the risks of allowing someone else to have access to my health records
* I have read and understand the information leaflet provided by the organisation

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature** |  | **Date** |  |

**Section 3b: Representative Details**

I/We wish to have access to the health records on **behalf of** the named patient

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Surname** |  |
| **First name** |  | **First name** |  |
| **Date of birth** |  | **Date of birth** |  |
| **Address** |  | **Address**  |  |
| **Postcode** |  | **Postcode** |  |
| **Email** |  | **Email** |  |
| **Telephone** |  | **Telephone** |  |
| **Mobile** |  | **Mobile** |  |

**Reason for access:**

|  |  |
| --- | --- |
| I have been asked to act by the patient  | 🞏 |
| I have full parental responsibility for the patient. The patient is between the age of 13-17 years and has consented to my making this request | 🞏 |
| I have full parental responsibility for the patient and the patient is under the age of 13 years  | 🞏 |

**Section 4: Consent to proxy access to GP Online Services (if patient does not have capacity)**

I/We wish to have access to the health records on **behalf of** the above-named patient

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Surname** |  |
| **First name** |  | **First name** |  |
| **Date of birth** |  | **Date of birth** |  |
| **Address** |  | **Address**  |  |
| **Postcode** |  | **Postcode** |  |
| **Email** |  | **Email** |  |
| **Telephone** |  | **Telephone** |  |
| **Mobile** |  | **Mobile** |  |

**Reason for access:**

|  |  |
| --- | --- |
| I/We have been appointed by the Court to manage the patient’s affairs and attach a certified copy of the court order appointing me to do so |  🞏 |
| I am/We are acting *in loco parentis* and the patient is incapable of understanding the request | 🞏 |
| I am/We are the deceased person’s personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration) | 🞏 |
| I/We have written and witnessed consent from the deceased person’s personalrepresentative and attach Proof of Appointment | 🞏 |
| I/We have a claim arising from the person’s death (please state details below) | 🞏 |

**Section 5: Proxy access online services available**

I/We wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| Booking appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| Access to full medical records | 🞏 |

**Section 6: Proxy declaration**

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement (tick)

|  |  |
| --- | --- |
| I/We will be responsible for the security of the information that I/we see or download | 🞏 |
| I/We will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement | 🞏 |
| If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential | 🞏 |

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 health records referred to above under the terms of the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted).

You are advised that the making of false or misleading statements in order to obtain

personal information to which you are not entitled is a criminal offence which could lead to prosecution.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant signature** |  | **Date** |  |

**Section 7: Proof of identity**

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However,each applicant/representative will be asked to provide a form of identification which must be photographic identification before access can be set up. Proxy access to children’s records will also require proof of parental responsibility i.e. Birth certificate/court order

Please speak to reception if you are unable to provide any of the above.

**For office use only:**

**Identification verification must be verified via either form below:**

* Photo ID for patient/Representative (e.g., passport or photo driving licence) Also evidence of parental responsibility for children (birth certificate or court order)
* When this is not available, vouching by a member of staff

|  |  |
| --- | --- |
| Date Request received. |  |
| Identification seen for | 🞏 Child (aged 13-17) | 🞏 Patient | 🞏 Representative/ Parents |
| Identity verified by (staff Name and signature) |  |
| Identity method | 🞏 Photo ID– Type: Passport / Driving licence / Home office ID / Other🞏 Vouching – by whom:🞏 Other – Birth Certificate |
| Form Reviewed by / Date: |  |
| Comments/actions taken |  |
| Proxy access authorised by |  |
| Level of medical records access enabled | □ All | □Prospective | □ Retrospective | □ Limited parts |
| Notes for proxy access*(If any request is refused, discuss with the organisation’s DPO before informing patient/applicant)* |  |