

Berry Lane Medical Centre
Request for access to personal health records

In confidence

N.B. Please complete all sections of this form. Sending an incomplete form may result in a delay to the processing of your request.

A fee of £10.00 plus copying charges (not to exceed £50.00) may be charged if the records have NOT been added to in the last 40 days.

Please write in capital letters and use black ink

1. Details of the patient whose record is to be accessed

Surname: _____

Former Surname(s): _____

Forename(s): _____

Address: _____

Former Address: _____

Post Code: _____ Tel No: _____

Please give any further information which may be of assistance in processing your request:

2. **Details of applicant** (if different from above)

Surname: _____

Forename(s): _____

Address to which reply should be sent if different from that of the patient:

3. **Declaration**

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 record referred to above under the terms of the Data Protection Act 1998 "Subject Access".

Delete the following as appropriate:

- I am the patient
- I have been asked to act on behalf of the patient and have completed **Part 1** of the authorisation (below).
- I am acting in loco parentis and the patient is under 16 and
 - A. Is incapable of understanding the request, or
 - B. Has consented to my making this request and has completed **Part 2** of the authorisation (below)
- I am the deceased patient's personal representative.
- I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that:

Signed: _____ Date _____

Authorisation

Part 1(on behalf of another person)

I _____ hereby authorise Berry lane Medical Practice to release any Personal Health Records it may hold relating to me to:

_____(name of person acting on your behalf) to whom I have given my consent to act on my behalf.

Signed: _____ Date: _____

Part 2 (in the case of a person under the age of 16)

I (name of applicant) _____

Of (address) _____

Certify that the patient *understands/is incapable of understanding the nature of this application.

Signed: _____ Date: _____

The following section must be completed in full. Failure to do so may result in your application being returned and, in turn, delaying your request for access.

4 Countersignature

To be completed by someone able to confirm your identity.

I (full name) _____ certify that the applicant

(name) _____ has been known personally to me as (insert in what capacity other than spouse or partner e.g. employee, client, patient etc)

_____ for _____ years and that I have witnessed the signing of the above declaration

Signed: _____ Date _____

Name: _____ Profession: _____

Contact telephone number: Daytime: _____

Evening: _____

As a matter of routine you may receive a telephone call asking you to confirm the applicant's identity:

Please return this form to: **Berry Lane Medical Centre**
Berry Lane
Longridge
Preston
Lancashire
PR33jj