**ACCESSING YOUR MEDICAL RECORDS AT SOVEREIGN PRACTICE.**

**Introduction**

In accordance with the General Data Protection Regulation, patients (data subjects) have the right to access their data and any supplementary information held by Sovereign Practice; this is commonly known as a data subject access request (DSAR). Data subjects have a right to receive:

* Confirmation that their data is being processed
* Access to their personal data
* Access to any other supplementary information held about them

**Options for access**

You are allowed to access your health record online**.** This service will enable the patient to view coded information held in their health record. Prior to accessing this information, **you will have to visit the practice and undertake an identity check before being granted access to your records.**

In addition, with the launch of the new **G**eneral **D**ata **P**rotection **R**egulations (**GDPR**, May 2018), you can make a request to be provided with copies of your health record. To do so, you must submit a Data Subject Access Request (DSAR) form; this can be submitted electronically and the DSAR form is available on the practice website. Alternatively, a paper copy of the DSAR is available from reception. You will need to submit the form online or return the completed paper copy of the DSAR to the practice. Patients do not have to pay a fee for copies of their records under DSAR but there are circumstances which there will be charges.

**Time frame**

Once the DSAR is submitted, Sovereign Practice will aim to process the request within 21 days; however, this may not always be possible. The maximum time permitted to process DSARs is one calendar month.

**Exemptions**

There may be occasions when the data controller (The Practice Manager, Graham Willoughby) will withhold information kept in the record, particularly if the disclosure of such information is likely to cause undue stress or harm to you or any other person.

**Data Protection Officer**

At Sovereign Practice the Data Protection Officer is Mike Hobden and the Deputy is Deirdre Spencer. Should you have any questions relating to accessing your medical records, please ask to discuss this with the above.

**APPLICATION FORM FOR ACCESS TO HEALTH RECORDS**

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

**DATA SUBJECT ACCESS REQUEST**

This form must be completed in blue or black ink and signed in order for us to process your request. We can only accept signed original forms. No emailed copies will be accepted.

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Maiden name** |  |
| **Forename** |  | **Title****(i.e. Mr, Mrs, Ms, Dr)** |  |
| **Date of Birth** |  | **Address** |  |
| **Telephone Number** |  | **Postcode** |  |
| **NHS Number (if known)** |  | **Email address** |  |
| **Hospital number (if known)** |  |  |  |

**Section 2: Record requested**

**PLEASE NOTE THAT IF YOU REGISTER FOR ONLINE ACCESS YOU CAN VIEW ALL YOUR RECORDS – This is the quickest way to have access to your records and also allows you to book appointments, view test results and order medication.**

Please be specific about the information that you require.

The more specific you can be, the easier it is for us to quickly provide you with the records requested, for example *- “Record in respect of treatment for (e.g. leg injury following a car accident in 2005)”*

|  |  |
| --- | --- |
| **Reason for the Request** | **Approved by – (Practice to complete this column)** |
|  |  |
| Please provide me with a summary to include medications, allergies and medical problems past and present: |  |
| Please provide me with a copy of records between the dates specified below: |  |
| Please provide me with a copy of records relating to the incident specified below: |  |
| Please provide me with a copy of records relating to the condition specified below: |  |
| Please provide me with a copy of all records held: |  |

**Section 3: Details and declaration of the applicant:** Please enter details of applicant *if different from Section 1*

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Title****(Mr, Mrs, Ms, Dr)** |  |
| **Forename (s)** |  | **Address** |  |
| **Telephone Number** |  | **Postcode** |  |

**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 records referred to above under the terms of the GDPR.

Please tick:

 I am the patient

 I have been asked to act by the patient and attach the patient’s written authorisation

 I have full parental responsibility for the patient and the patient is under the age of 18 and:

1. has consented to me making this request, or
2. Is incapable of understanding the request (delete as appropriate

 I 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 acting *in loco parentis* and the patient is incapable of understanding the request.

 I am the deceased person’s Personal representative and attach confirmation of my

 appointment (Grant of Probate / Letters of Administration).

 I have written, and witnessed, consent from the deceased person’s Personal Representative

 and attach Proof of Appointment.

 I have a claim arising from the person’s death (Please state details below).

Signature of applicant: …………………………………………………………. Date: ………………………………………….

 **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.**

**Section 4: Proof of Identity**

Please indicate how proof of ID has been confirmed. Please select ‘A’ or ‘B’:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Method in which identity is confirmed** | **Option taken** | **Documents attached** |
| A | Attached copies of documents as noted in section 4A below | Yes / No | If yes, please indicate here which documents have been attached: |
| B | Countersignature (section 4B). This should only be completed in exceptional circumstances (e.g in cases where the above cannot be provided) | Yes / No | Please indicate why this section was completed: |

 **4A – Evidence:**

**Evidence of the patient’s and / or the patient’s representative identity will be required. Please attach copies of the required documentation to this application form. Examples of the required documentation are:**

|  |  |  |
| --- | --- | --- |
|  | **Type of Applicant** | **Type of Documentation** |
| **A** | An individual applying for his / her own records | One copy of identity required e.g. copy of birth certificate, passport, driving licence PLUS one copy of a utility bill or medical card etc. |
| **B** | Someone applying on behalf of an individual (Representative) | One item showing proof of the patient’s identity and one item showing proof of the representative’s identity (see examples ‘A’ above. |
| **C** | Person with parental responsibility applying on behalf of a child | Copy of birth certificate of child & copy of correspondence addressed to person with parental responsibility relating to the patient. |
| **D** | Power of Attorney / Agent applying on behalf of an individual | Copy of a Court order authorising Power of Attorney / Agent PLUS proof of the patient’s identity (see examples in ‘A’ above) |

# 4B – Countersignature

**This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section may be completed if 4A cannot be fulfilled.**

I (insert full name)………………………………………………………………………………………………………………………………

Certify that the applicant (insert name) ……………………………………………………………………………………………..

Has been known to me personally as ………………………………………………. for ……………………………….. years

(insert in what capacity, e.g. employee, client, patient, relative etc.)

And that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed……………………………………………………………………………………………………….. Date ……………………………

Name ………………………………………………………………….. Profession ……………………………………………………………………………...

Address …………………………………………………………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………………………………………………………………..

Daytime telephone number ……………………………………………………………………………………………………………………………………

|  |
| --- |
| **Additional notes:**Before returning this form, please ensure that you have:a)signed and dated this formb) enclosed proof of your identity or alternatively confirmed your identity by a countersignaturec) enclosed documentation to support your request (if applying for another person’s records). Incomplete applications will be returned; therefore please ensure you have the correct documentation before returning the form. |