WICKHAM PARK SURGERY

|  |  |
| --- | --- |
| Dr Adelaja Mustapha  Dr Abimbola Mustapha  Dr Ruth Tinson  Dr Sunjesh Vaja  Dr Bhumika Mittal | 2 Manor Road  West Wickham  Kent BR4 9PS  Tel: 020 8777 1293  Email: broccg.wickhamparksurgery@nhs.net  www.wickhamparksurgery.org |

**Details of the record to be accessed:**

|  |  |
| --- | --- |
| Patient Surname |  |
| Forename(s) |  |
| Date of Birth |  |

**Details of the person who wishes to access copies of the records, if different to above:**

|  |  |
| --- | --- |
| Surname |  |
| Forename(s) |  |
| Address |  |
| Telephone Number |  |
| Relationship to Patient |  |

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 Data Protection Act 1998.

Tick which of the following statements apply

* I am the patient.
* I am acting on behalf of the patient and have power of attorney over health and wellbeing (must be documented on patients medical records)
* I am acting in Loco Parentis and the patient is under age sixteen, and is incapable of understanding the request / has consented to me making this request.

(\*delete as appropriate).

* I am the deceased patient’s Personal Representative and attach confirmation of my appointment.
* I have a claim arising from the patient’s death and wish to access information relevant to my claim on the grounds that….(please supply your reasons below).

**Patient’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person requesting copies of medical records, aged over 16 (including parents/guardians)**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(CODE 9N5A)

**Notes:**

Under the Data Protection Act 1998 you do not have to give a reason for applying for access to your health records.

However please use this space below to inform us of certain periods and parts of your health record you are requesting, or provide more information. This will help us to process your application quicker.

This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports.

* Entire medical record
* Records between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Records regarding (eg, specific health condition or diagnosis. Continue on a separate page if needed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_