MALVERN FAMILY PRACTICE

SUBJECT ACCESS REQUEST MEDICAL RECORDS APPLICATION FORM

I am applying for a copy of my medical record in accordance with the Data Protection Act 2018

DETAILS OF THE RECORD REQUIRED (the first two sections plus date of birth must match our data)

Surname (Family Name)	
First Name(s)	
Previous Name(s)	
Date of Birth	
Telephone/contact number	
Email address	
Date of application	

Please specify what part(s) of the record is required – it would greatly help the Practice if you can be as specific as possible and only request records for a certain period of time/limited time, if that is what you require i.e. records between 2015-present etc.

Although we have no legal right to insist on knowing the reason for you wanting to access your records, if you are able to inform us of the reason, we will be able to make sure we give you the most appropriate information for your needs. For example, if you plan to pass the data onto a third party who is assessing you or action on your behalf, we will be able to ensure we help you protect your personal information by only providing them with the necessary information.

Record Type/ Medical History	Please use the space below to specify which part of the Health Record is required, i.e. records covering particular treatment or between given dates
• **X-Rays, MRI or CT Scans** • **Cardiac /EEG/ECG Traces**	

Other Imaging Media	
• **Therapy Records**	
• **Computerised information**	
• **Other data (please specify)**	
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Please tick the appropriate box	
I am applying for a copy of my own records	
I am a parent/guardian of a patient under 16 who has consented to this request	
I am the deceased persons representative and attach confirmation of this fact	
Acting on behalf of consenting person, attached authorisation	
Other Request – please give supporting information	
please note if you are applying on behalf of someone else, the GP will contact them to gain prior approval before we can proceed	
Once the information leaves the Practice it is the patient's responsibility.	

Print Name of Applicant		**Signature of Applicant**	
Address of Applicant			

Send the completed form to:

Malvern Family Practice

First floor Cornerstone Medical Centre

69 Shankill Road

Belfast BT13 1FD