

**APPLICATION FOR ACCESS TO HEALTH RECORDS**  
Abbey Road Medical Practice

Details of Health Records to be accessed:

**PATIENT**

Surname: .....

Maiden Name: .....

Forename(s): .....

Address: .....  
.....

Date of Birth: .....

**RECORDS**

Please indicate the copy records you require:    Copy paper Medical Records     Copy electronic medical record

In respect of: (please give details of condition/illness/treatment)  
.....  
.....

Dates of Treatment: .....

Consultant: .....

Reason for Application would be helpful: .....  
.....

**APPLICANT** (if different from the patient)

Surname: .....

Forename(s) .....

Address: .....  
.....

Relationship to patient: .....

**DECLARATION** Please tick the relevant box and sign below

I declare that the information given by me is to the best of my knowledge correct 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.

1.  I am the patient.
2.  I have been asked to act by the patient and attach the patient's written consent.
3.  The patient is under the age of 16. I am a parent.  
(Guardians and others acting in place of parents will have to supply proof of status)
4.  I am the deceased patient's next of kin.
5.  I am the deceased patient's personal representative and attach confirmation of my appointment.
6.  I have a claim arising from the patient's death on the grounds that:

.....  
.....

Signed: ..... Date: .....

**Consent (If requesting on patient behalf)**

Patient's Name.....

Address.....

.....

.....

Date of Birth.....

I ..... hereby authorise you to provide my representative..... with any information that they may require regarding my state of health and to provide them with any information that you may hold in respect of me.

Patient's Signature.....  
Date.....  
Representatives Name.....  
Representatives Signature.....  
Date.....  
Authorisation.....  
Date.....

FOR OFFICE USE ONLY

**CERTIFICATION OF ABOVE SIGNATURE:**

**THIS SECTION MUST BE COMPLETED BY SOMEONE WHO KNOWS YOU AS INDICATED IN THE DECLARATION BELOW.**

I certify that I am (name): .....  
of (address): .....  
.....

and that I have known the above applicant named above for ..... years as an employee / client / patient / personal friend (please delete as appropriate) and have witnessed the applicant sign this form.

Documents used to verify:

- Photo ID
- Other (specify) .....

Signed: ..... Date: .....