Tain & District Medical Group
Access to Health Records & Requests for other personal information

GDPR 2018, for living patients
ACCESS TO HEALTH RECORDS ACT 1990, for deceased patients

Section 1 - Details of person whose records are being requested.

Surname.....
Former Surname if applicable.....
First Name (s).....
Date of Birth.....
Registered Address.....
Current Address if different from above.....
.....
Postcode..... Daytime telephone number.....
Email address ……..

I received the leaflet "How to request GP Records & Other personal information" ☐

Section 2 – What information is required?

Please note this is a 28 day service, please alert us if your requirements are more urgent

A DWP/PIP information summary report only ☐

To view your health records ☐

A copy of records for date range ☐

From.....to.....

A letter or statement from a GP (there will likely be a fee for this) ☐

Other (please specify below) ☐

Section 3

Please give full details of what the information will be used for

Section 4

Please use the space below for further information you feel is relevant to this application

Section 5 - Declaration –

I declare that the information given by me in sections 1-4 is correct to the best of my knowledge and that I am entitled to apply for this information.

Please tick appropriate box:

- ☐ I am the patient
- ☐ I have been appointed by the court to manage the affairs of the patient and attach relevant documentation
- ☐ I am acting on behalf of the patient and the patient has completed the authorisation (section 5)
- ☐ I am the deceased patient's representative and attach confirmation of my status
- ☐ I have Welfare Power of Attorney for this patient and attach relevant documentation
- ☐ Other, specify.....

Patient or Applicant's name ……..……

Patient or Applicant's signature.....DATE.....

Address if different from above…….....

Daytime telephone number.....……..……..

Please ignore this section if you are requesting your own health records/personal information

Section 6 - Patient's Authorisation

I authorise Tain & District Medical Group to release the information requested

to.....
Whom I have given consent to act on my behalf.

Signature
…….....……Date...…….
Please return this form to Practice Manager, SAR, Tain & District Medical Group, Health Centre, Craighill Terrace, Tain IV19 1EU
Remember that you will need to have your ID verified at the Practice.
Confirmation of identity (OFFICE USE ONLY)
ID checked/Patient verified

Patient verified by..... Date.....