PATIENT ACCESS TO MEDICAL RECORDS POLICY

INTRODUCTION

The Access to Health Records Act 1990 and the Access to Medical Reports Act 1988 gave individuals the right of access, subject to certain exceptions, to health information recorded about themselves, and in certain circumstances, about others, within manual records. The Data Protection Act (DPA) 1998 came into force in March 2000 and repealed most of the 1990 Access to Health Records Act. All applications for access to records, whether paper based or electronic, of living persons are now made under the DPA 1998. In February 2010 the Department of Health published amended guidance applicable in England to encompass best practice covering the above legislative process, replacing previous guidelines issues in July 2002 and June 2003. Practices are recommended to refer to these guidelines where an access request is received.

For deceased persons, applications are made under sections of the 1990 Access to Health Records Act which has been retained. These sections provide the right of access to the health record of deceased individuals for their personal representative and others having a claim under the estate of the deceased.

The Access to Medical Reports Act 1988 covers the rights of individuals to access medical reports prepared about them for employment or insurance purposes.

Under section seven of the DPA, patients have the right to apply for access to their health records. Provided that the fee has been paid and a written application is made by one of the individuals referred to below, the practice is obliged to comply with a request for access subject to certain exceptions. However, the practice also has a duty to maintain the confidentiality of patient information and to satisfy itself that the applicant is entitled to have access before releasing information.

The purpose of this policy is to provide information on the patient’s rights to view medical reports prepared on his/her behalf in connection with insurance or employment and guidance on application to gain copies of medical correspondence.

The rights of patients are governed within the Access to Medical Reports Act 1988 and apply to medical reports prepared by the GP responsible for the clinical care of that patient (i.e. the registered GP practice). Where a report is prepared for similar purposes by an alternative medical practitioner, for example a doctor employed by an insurance company or employer, then these reports do not fall within the scope of the regulations. In these circumstances the Data Protection Act 1998 will apply.

WHAT CONSTITUTES A HEALTH RECORD?

A health record could include, and not exhaustively, hand-written clinical notes, letters between clinicians, lab reports, radiographs and imaging, videos, tape-recordings, photographs and monitoring printouts. Records can be held in both manual or computerised medias.

APPLICATIONS

An application for access to health records may be made in any of the circumstances explained below:
THE PATIENT

Weobley & Staunton on Wye Surgeries has a policy of openness with regard to health records and health professionals are encouraged to allow patients to access their health records on an informal basis. This should be recorded in the health record itself. The Department of Health’s Code of Practice on Openness in the NHS as referred to in HSG (96) 18 Protection and Use of Patient Information will still apply to informal requests.

Such requests are usually made for a reason and will always be in writing. There is no requirement to allow immediate access to a record of any type. A valid written request should be accompanied by the appropriate fee. The patient may have concerns about treatment that they have received, how they have been dealt with or may be worried that something they have said has been misinterpreted. Members of staff are encouraged to try to understand and allay any underlying concerns that they have contributed to the request being made and offer an opportunity of early resolution.

CHILDREN & YOUNG PEOPLE

Children over the age of 12 are generally considered to have the capacity to give or withhold consent to release medical records. In Scotland, there is a legal assumption that this is the case, but not in England, Wales or Northern Ireland where those under 16 should demonstrate that they have the capacity to make these decisions. Where the child is considered to be capable, then their consent must be sought before access is given to a third party.

The law regards young people aged 16 or 17 to be adults in respect of their rights to confidentiality. Access can be refused by the health professionals where they consider that the child does not have capacity to give consent/decline decisions.

Individuals with parental responsibility for an under 18 year old will have a right to request access to those medical records (Scotland under 16). Access may be granted if access is not contrary to the wishes of the competent child. Not all parents have parental responsibility. A person with parental responsibility is either:

- The birth mother, or
- The birth father (if married to the mother at the time of the child’s birth or subsequently) if both are on the birth certificate, or
- An individual given parental responsibility by a court

Parental responsibility is not lost on divorce. If parents have never been married only the mother has automatic parental responsibility, however the father may subsequently ‘acquire’ it.

If the appropriate health professional considers that a child patient is Gillick competent (ie. Has sufficient maturity and understanding to make decisions about disclosure of their records) then the child should be asked for his or her consent before disclosure is given to someone with parental responsibility.

If the child is not Gillick competent and there is more than one person with parental responsibility, each may independently exercise their right of access. Technically, if a child lives with, for example, its mother, and the father applies for access to the child’s records, there is no ‘obligation’ to inform the mother. In practical terms, however, this may not be possible and both parents should be made aware of access requests unless there is a good reason not to do so.

In all circumstances good practice dictates that a Gillick competent child should be encouraged to involve parents or other legal guardians in any treatment/disclosure decisions. The Data Controller may refuse access to the record where the information contained in it could cause serious harm to the patient or another person.
PATIENT REPRESENTATIVES

A patient can give written authorisation for a person (eg. a solicitor or relative) to make an application on their behalf. The Practice may withhold access if it is of the view that the patient authorising the access has not understood the meaning of the authorisation.

COURT REPRESENTATIVES

A person appointed by the court to manage the affairs of a patient who is incapable of managing his or her own affairs may make an application. Access may be denied where the GP is of the opinion that the patient underwent relevant examinations or investigations in the expectation that the information would not be disclosed to the applicant.

CHILDREN AND FAMILY COURT ADVISORY AND SUPPORT SERVICE (CAFCASS)

Where CAFCASS has been appointed to write a report to advise a judge in relation to child welfare issues, Weobley & Staunton on Wye Surgeries would attempt to comply by providing factual information as requested.

Before records are disclosed, the patient or parents’ consent (as set out above) should be obtained. If this is not possible, and in the absence of a court order, the practice will need to balance its duty of confidentiality against the need for disclosure without consent where this is necessary:

- To protect the vital interests of the patient or others, or
- To prevent or detect any unlawful act where disclosure is in the substantial public interest (eg. serious crime), and
- Because seeking consent would prejudice those purposes

The relevant health professional should provide factual information and their response should be forwarded to a member of the Child Protection Team who will approve the report.

CHAPTER 8 REVIEW

All Chapter 8 Review requests for information should be immediately directed to the Primary Care Organisation Child Protection Manager who would co-ordinate the Chapter 8 Review in accordance with national and local Area Child Protection Committee Guidance.

AMENDMENTS TO OR DELETIONS FROM RECORDS

If a patient feels information recorded on their health record is incorrect then they should firstly make an informal approach to the health professional concerned to discuss the situation in an attempt to have the records amended. If this avenue is unsuccessful then they may pursue a complaint under the NHS Complaints procedure in an attempt to have the information corrected or erased. The patient has a right under the DPA to request that personal information contained within the medical records is rectified, blocked, erased or destroyed if this has been inaccurately recorded.

He or she may apply to the Information Commissioner but they could also apply for rectification through the courts. The GP Practice, as the Data Controller, should take reasonable steps to ensure that the notes are accurate and if the patient believes these to be inaccurate, that this is noted in the records. Each situation will be decided upon the facts and the practice will not be taken to have contravened the DPA if those reasonable steps were taken. In the normal course of events, however, it is most likely that these issues will be resolved amicably.

Further information can be obtained from the Information Commissioner at Wycliffe House, Water Lane, Wilmslow, Cheshire. SK9 5AF. Telephone: 01625 545700.
PROCESS

GP Practices receive applications for access to records via a number of different sources, eg:

- Patient’s solicitors
- Patients and relatives
- Patient Carers
- Parents of Patients under 16 years old

Requests should be in writing, with a patient signature using the appropriate form. Where a solicitor or other representative is making the request, patient signed consent must be provided and sufficient information to clearly identity the patient.

NOTIFICATION OF REQUESTS

Practices should treat all requests as potential claims for negligence. Good working practice would be to keep a central record of all requests in order to ensure that requests are cross-referenced with any complaints or incidents and that the deadlines for response are monitored and adhered to.

REQUIREMENT TO CONSULT APPROPRIATE HEALTH PROFESSIONAL

It is the GP’s responsibility to consider an access request and to disclose the records if the correct procedure has been followed. Before the practice discloses or provides copies of medical records/correspondence the patient’s GP must have been consulted and he/she checked the records and authorised the release, or part-release.

GROUNDS FOR REFUSING DISCLOSURE TO HEALTH RECORDS

The GP should refuse to disclose all or part of the health record is he/she is of the view that:

- Disclosure would be likely to cause serious harm to the physical or mental health of the patient or any other person
- The records refer to another individual who can be identified from that information (apart from a health professional). This is unless that other individual’s consent is obtained or the records can be anonymised or it is reasonable in all the circumstances to comply with the request without that individual’s consent, taking into account any duty of confidentiality owed to the third party; or if
- The request is being made for a child’s records by someone with parental responsibility or for an incapacitated person’s record by someone with power to manage their affairs, and the:
  - Information was given by the patient in the expectation that it would not be disclosed to the person making the request, or
  - The patient has expressly indicated it should not be disclosed to that person

INFORMING OF THE DECISION NOT TO DISCLOSE

If a decision is taken that the record should not be disclosed, a letter must be sent by recorded delivery to the patient or their representative stating the disclosure would be likely to cause serious harm to the physical or mental health of the patient, or to any other person. The general position is that the practice should inform the patient if records are to be withheld on the above basis. However, the GP could decide not to inform the patient if the appropriate health professional thinks that telling the patient:

- Will effectively amount to divulging that information, or this
- Is likely to cause serious physical or mental harm to the patient or another individual

In either of these cases an explanatory note should be made in the file. The decision can only be taken by the GP. Although there is no right of appeal to such a decision, it is the Practice’s policy to give a patient
the opportunity to have their case investigated by invoking the Complaints Procedure. The patient must be informed in writing that assistant will be offered to them if they wish to do this. In addition, the patient may complain to the Information Commissioner for an independent ruling on whether non-disclosure is proper.

DISCLOSURE OF THE RECORD

Once the appropriate documentation has been received and sufficient identification has been produced to satisfy the Data Controller that disclosure can be made, disclosure can be approved, the copy of the health record may be sent to the patient or their representative in a sealed envelope by recorded delivery or the patient can retrieve this in person however a form of ID will need to be shown at the time of collection. The record should be sent to a named individual, marked confidential, for addressee only and the sender’s name should be written on the reverse of the envelope. Originals should not be sent. It would be good practice to check with the patient that all of the information requested is needed, before fulfilling the request, although there is no requirement under the Act to specify the extent of the requested information as part of the application procedure.

Where viewing is requested a date may be set for the patient to view by supervised appointment. Where parts of the record are not to be released or to be viewed (eg. they are restricted) an explanation does not have to be given, however the reasons for withholding should be documented. An explanation of terminology, abbreviation etc must be given if requested. It is also good practice for viewings to be supervised by a clinician who can explain items if needed. Where a non-clinician does this then no explanation must be offered. Explanation requests should then be referred to a clinical member of staff. A note should be made in the file of what has been disclosed to whom and on what grounds.

Where information is not readily intelligible an explanation (eg of abbreviations or medical terminology) must be given. Where an access request has been fulfilled a subsequent identical or similar request does not have to be again fulfilled unless as ‘reasonable’ time interval has elapsed. However, Weobley & Staunton on Wye Surgeries reserve the right to charge for repeated requests for correspondence copies due to the administration time involved in doing so.

Confidential information should not be sent by fax and never by email unless via an encrypted service such as from one NHS mail account to another NHS mail account.

CHARGES AND TIMESCALES

The DPA states that fees should be paid in advance. Charges are set-out in the Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000.

Copies of records should be supplied within 21 days of receiving a valid and complete access request. In exceptional circumstances, it may take longer. The original Access to Health Records Act 1990 required requests to be complied with within 21 days where the record had been amended within 40 days, however the new Data Protection Act which replaced this requires 40 days for all requests. Ministers gave a commitment to Parliament that 21 days would be retained for the NHS. 21 days is therefore the required standard, 40 days may apply in some exceptional circumstances, and if this is to be the case the patient should be advised prior to expiry of the initial 21 day period.

Where further information is required by the Practice to enable it to identify the record required or validate the request, this must be requested within 14 days of receipt of the application and the timescale for responding begins on receipt of the full information.

To provide codes of electronic patient health records a maximum charge of £10 can be requested to cover printing. For manual records, or a mixture of electronic and manual, there can be a maximum charge of £50 but Weobley & Staunton on Wye Surgeries will disclose the charges applicable (An additional fee of 35p per page if records are to be photocopied) to each individual dependent upon the administration time required to complete the request. When a GP is formally asked to inspect a record that does not belong to him, a fee of £50 will be charged.
Inspection of records of any type without copies, including those held only in electronic form, will incur a £10 charge. It is normal for inspection to be supervised. If the record has been added to in the preceding 40 days, there is no charge if the patient wishes to view the record. All charges include copying, postage and packaging.

The Practice is not obliged to provide all the information requested if this would involve disproportionate effort. This however would only apply in very exceptional circumstances and may need to be justified to the Information Commissioner in the event of a dispute. At the same time however, the GP has discretion not to charge for copies should he/she choose to do so.

APPROPRIATE HEALTH PROFESSIONAL

The Data Protection (Subject Access Modification) (Health) Order 2000 specifies the appropriate health professional to deal with access matters is:

- The current or most recent responsible professional involved in the clinical care of the patient in connection with the information aspects which are the subject of the request, or
- Where there is more than one such professional, the most suitable is to advise on the information which is the subject of the request

SAFE HAVEN

Confidential medical records should not be sent by fax unless there is no alternative. If a fax must be sent, it should include the minimum information and names should be removed and telephoned through separately.

All staff should be aware that safe haven procedures apply to the sending of confidential information by fax, for whatever reason. That is, the intended recipient must be alerted to the fact that confidential information is being sent. The recipient then makes a return telephone call to confirm safe and complete receipt. A suitable disclaimer, advising an unintentional recipient to contact the sender and to either send back or destroy the document, must accompany all such faxes.

FORMER NHS PATIENTS LIVING OUTSIDE THE UK

For former patients living outside of the UK and whom once had treatment for their stay here, under the DPA 1998 they still have the same rights to apply for access to their UK health records. Such a request should be dealt with as someone making an access request from within the UK. Original records should not be given to a patient to take outside the UK. The GP may agree to provide a summary but the request is subject to a normal access request under these provisions.

REQUESTS MADE BY TELEPHONE

No patient information may be disclosed to members of the public by telephone. However, it is sometimes necessary to give patient information to another NHS employee over the telephone. Before doing so, the identity of the person requesting the information must be confirmed. This may be best achieved by telephoning the person’s official office and asking to be put through to their extension. Requests from patients must be made in writing.

REQUESTS MADE BY THE POLICE

In all cases, the practice can release confidential information if the patient has given his/her consent (preferably in writing) and understands the consequences of making that decision. There is, however, no
legal obligation to disclose information to the police unless there is a court order or this is required under statute (eg. Road Traffic Act).

The Practice does however, have a power under the DP and the Crime Disorder Act to release confidential health records without consent for the purposes of the prevention or detection of crime or the apprehension or prosecution of offenders. The release of the information must be necessary for the administration of justice and is only lawful if this is necessary:

- To protect the patient or another person’s vital interests, or
- For the purposes of the prevention or detection of any unlawful act where seeking consent would prejudice those purposes and disclosure is in the substantial public interest (eg. where the seriousness of the crime means there is a pressing social need for disclosure)

Only information which is strictly relevant to a specific police investigation should be considered for release and only then if the police investigation would be seriously prejudiced or delayed without it. The police should be asked to provide written reasons why this information is relevant and essential for them to conclude their investigations.

REQUESTS FOR INSURANCE PURPOSES

Insurance companies may seek to obtain full medical records through the use of Subject Access Requests (SAR) under the Data Protection Act 1998. After seeking clarification from ICO, the BMA advised that upon receiving a SAR from an insurance company, practice should contact the patient to explain the implications of such a request and the extent of the disclosure. The ICO is also clear that GPs should provide the SAR information to the patient themselves, rather than directly to the insurance company.

The ICOs Subject Access Code of Practice states that ‘if you think an individual may not understand what information would be disclosed to a third party who has made a SAR on their behalf, you may send the response directly to the individual rather than to the third party. The individual may then choose to share the information with the third party after having had a chance to review it’.

It is however expected that insurance companies will stop requesting SARs and revert to requesting medical reports. Practices are able to apply a fee for completion of these reports, in line with the work associated, and should seek to agree the fee with the requester in advance of completion.

REQUESTS FROM THIRD PARTIES FOR NON-INSURANCE PURPOSES

Under the Data Protection Act, individuals are entitled to make a SAR via a third party, such as solicitors who are acting in civil litigation cases for patients. These parties should obtain consent from the patient using the form that has been agreed with the BMA and the Law Society:


The ICO Code of Practice states that ‘in these cases, you need to be satisfied that the third party making the request is entitled to act on behalf of the individual, but it is the third party’s responsibility to provide evidence of this entitlement. This might be a written authority to make the request or it might be a more general power of attorney’.

PRACTICE PROCEDURES

INITIAL PROCESS

When a request has been received the subsequent steps must be followed:
• On opening/receiving correspondence, Reception Team to write on correspondence date received
• Request is passed on to the Secretary
• Check that patient registered at Practice and if not inform sender
• Lloyd George notes (if applicable) retrieved by the Secretary
• Secretary will log receipt onto spreadsheet (if at Weobley and patient is registered at Staunton request will be forwarded to Staunton and vice versa)
• Consent form must be attached to request – if not, request this from the sender. Proceed no further until consent form has been received.

PROCEDURE FOR INSURANCE REPORTS

• Consent form must be attached to request – if not, request this from the sender. Proceed no further until consent form has been received.
• Enter onto spreadsheet that notes have been passed to nurse who does insurance reports
• Once completed, report returned to secretary. Pass this on for GP to check and sign (enter on spreadsheet)
• Invoice insurance company/requester of information (update spreadsheet)
• When payment received indicate on spreadsheet
• If patient has indicated they wish to see copy of report then contact them to make arrangement for them to see or post. Once confirmation received that they are happy with the report then proceed as below.
  • Copy report and file in separate folder.
  • Post out report (enter on spreadsheet)

PROCEDURE FOR SOLICITOR REPORTS

• Consent form must be attached to request – if not, request this from the sender. Proceed no further until consent form has been received.
• Enter onto spreadsheet that notes have been passed to GP who does solicitor reports
• Once completed, report returned to secretary (enter on spreadsheet)
• Invoice solicitor prior to sending report (update spreadsheet)
• When payment received indicate on spreadsheet and forward report
• If patient has indicated they wish to see copy of report then contact them to make arrangement for them to see or post. Once confirmation received that they are happy with the report then proceed as below.
  • Copy report and file in separate folder.

PROCEDURE FOR PATIENT/RELATIVE REQUESTS FOR COPIES OF MEDICAL RECORDS

• Ensure that applicant has completed the Application for Access to Medical Records Form and signed the declaration
• Check Application Form to establish whether it is a patient or another person requesting access
• If another person is requesting access review the statements of intent and proceed in line with the Access to Medical Records (Data Protection Act) Policy
• Check Application Form to identify whether there are any limitations to access for another person
• Check that applicant/nominated person has provided proof of identity
• Print off all records held on computer (if appropriate)
• Print off all records held on Docman (if appropriate)
• Photocopy all paper notes in Lloyd George (single sided) (if appropriate)
• Collate and send to Reception Manager (enter on spreadsheet) who checks for third party references
• Once returned from Reception Manager, tippex out any highlighted references and rephotocopy the page
• Raise invoice for appropriate amount (enter on spreadsheet)
• Pass on to GP to check (enter on spreadsheet)
- Once cheque received and notes received back from GP post out records **recorded delivery** (enter on spreadsheet date posted) (or post in envelope provided)
- File copy of consent form with receipt from Post Office into insurance reports folder
- Pass original Application for Access to Medical Records Form to the Practice Manager

**PROCEDURE FOR PATIENT/RELATIVE REQUESTS FOR REVIEWING OF ELECTRONIC MEDICAL RECORDS**

- Ensure that applicant has completed the Application for Access to Medical Records Form and signed the declaration
- Check Application Form to establish whether it is a patient or another person requesting access
- If another person is requesting access review the statements of intent and proceed in line with the Access to Medical Records (Data Protection Act) **Policy**
- Check Application Form to identify whether there are any limitations to access for another person
- Check Application Form to ensure the patient has given consent to another person accessing their records (if applicable)
- Raise invoice for £10 and post (enter on spreadsheet)
- File copy of consent form with receipt from Post Office into insurance reports folder
- Once payment received, Secretary to arrange with the applicant/nominated person a convenient time to access the record
- Check that applicant/nominated person has provided proof of identity on arrival at the Practice
- Secretary to discuss with the relevant GP the limit of the disclosure and identify whether access would be best undertaken in the presence of a nurse, rather than an administrator
- Pass original Application for Access to Medical Records Form to the Practice Manager

**COMPLAINTS**

The Weobley & Staunton-On-Wye Surgeries has procedures in place to enable complaints about access to health records requests to be addressed.

The following channels are used to field any complaints regarding the access of health records at the Practice:

- Firstly, the clinician involved should arrange to have an informal meeting with the individual to try to resolve the complaint locally;
- If the issue remains unresolved, the patient should be informed that they have a right to make a complaint through the NHS complaints procedure (further information is available at: [http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/what_to_do.aspx](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/what_to_do.aspx))

Sometimes the patient may not wish to make a complaint through the NHS Complaints Procedure and instead, take their complaint direct to the Information Commissioner's Office (ICO) if they believe the Practice is not complying with their request in accordance with the Data Protection Act. Alternatively, the patient may wish to seek legal independent advice.
Confidentiality Notice

This document and the information contained therein is the property of The Weobley & Staunton-On-Wye Surgeries. This document contains information that is privileged, confidential or otherwise protected from disclosure. It must not be used by, or its contents reproduced or otherwise copied or disclosed without the prior consent in writing from The Weobley & Staunton-On-Wye Surgeries.

Document Revision and Approval History

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Appendix A

Weobley & Staunton on Wye Surgeries

APPLICATION FOR ACCESS TO MEDICAL RECORDS

DATA PROTECTION ACT 1998 SUBJECT ACCESS REQUEST

Section 1 - Details Of The Record To Be Accessed:

<table>
<thead>
<tr>
<th>Patient Surname</th>
<th>Forename(s)</th>
<th>Address</th>
<th>Date of Birth</th>
<th>NHS Number</th>
</tr>
</thead>
</table>

If you are applying to view your own records please go to Section 2. If you are applying to view another person’s record please go to Section 3.

Section 2 - Details of the Application

To be completed if you are the Patient named above:

<table>
<thead>
<tr>
<th>I confirm I am the patient named above</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am applying for access to view my records only</td>
<td>□</td>
</tr>
<tr>
<td>I am applying for copies of my medical record</td>
<td>□</td>
</tr>
<tr>
<td>I have instructed someone else to apply on my behalf and have indicated below if there are any limitations to access.</td>
<td>□</td>
</tr>
</tbody>
</table>
Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Section 3 - Details Of The Person Who Wishes To Access The Records**

To be completed if you are requesting access on behalf of the Patient named above:

<table>
<thead>
<tr>
<th>Surname</th>
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<tbody>
<tr>
<td>Forename(s)</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Relationship to Patient</td>
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</table>

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

**Which of the following statements apply:**

<table>
<thead>
<tr>
<th>Statement</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been asked to act by the patient and they have signed the declaration below</td>
<td>☐</td>
</tr>
<tr>
<td>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).</td>
<td>☐</td>
</tr>
<tr>
<td>I am the deceased patient’s Personal Representative and attach confirmation of my appointment.</td>
<td>☐</td>
</tr>
</tbody>
</table>
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).

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.

I agree to pay the appropriate fee for the disclosure required.

Applicant Signature

Date

I confirm that I give permission for the Practice to communicate with the person identified above in regards to my medical records.

Signature

Date

Section 4 – Records Required

- Under the Data Protection Act 1998 you do not have to give a reason for applying for access to your health records.
- You will be asked to provide photographic identification
- Please use this space below to inform us of certain periods and parts of the health record you may require, or provide more information as requested above.
- This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports.

I would like a copy of all records

I would like a copy of records between specific dates only (please give date range) below

I would like copy records relating to a specific condition/specific incident only (please detail below)
Section 5 - Consent for children under 16 (Gillick Competence)

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally ‘competent’ younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

<table>
<thead>
<tr>
<th>I am the Patient/Parent/Guardian (delete as necessary)</th>
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<tbody>
<tr>
<td>Signature</td>
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<tr>
<td></td>
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<tr>
<td>Full Name</td>
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<td>Address</td>
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PROCESS FOR PATIENT ENQUIRY
ACCESS TO MEDICAL RECORDS

Access to Medical Records - Patient Enquiry

Has Patient provided a written request?

- Yes: Provide Form
- No: Has the record been added to in the last 40 days?

Are copies required?

- Yes: Check that:
  - Form is fully completed
  - You can positively identify the patient
  - That the information required is specific
  - That you have a valid consent
  - That the patient has received a copy of the Fees and Charges leaflet

- No: Advise Patient that:
  - The request will be actioned as soon as possible, and within a maximum of 21 days
  - That they will be contacted when the request has been completed.
  - That requests to view will be by appointment with the Practice Nurse.

Prepare copies / printouts

Pass to Usual GP to Check

Advise patient copies are ready to collect

Advise patient to make a double appointment with the nurse to view
Who Can help with your Complaint?

Further information about the NHS Complaints Procedure is available on the NHS Choices website at:

www.nhs.uk/aboutNHSChoices/pages/Howtocomplaincompliment.aspx

Alternatively you can contact:

The Information Commissioners Office
Wycliffe House,
Water Lane,
Wilmslow,
Cheshire.
SK9 5AF
Telephone: 01625 545745
Email: www.ico.gov.uk

Terms Used

Data Controller – this is the controller of the data and the system, as defined in the Data Protection Act 1988.

Data Subject – This is the person whose image is within the system, and who has rights of access as determined under the Data Protection Act 1998.

Third Party – A person or body other than the Data Subject who requests access, or to whom an image may be provided.

Deceased Records – Covered by the Access to Medical Records Act 1990 for:

The personal representative who has died - Any person who may have a claim resulting from the person’s death
Access to Health Records under the Data Protection Act 1998

The Data Protection Act 1998 gives every living person, or an authorized representative, the right to apply for access to their health records.

A request for your medical health records held at the Weobley & Staunton on Wye Surgeries should be made in writing (emails also accepted) to the data controller who is the Practice Manager (please contact the Practice for alternative methods of obtaining access if you are unable to make a request in writing). Please ask within the Practice for an appropriate request form.

Under the Data Protection Act 1998 (Fees and Miscellaneous Provisions) Regulations 2000, you may be charged a fee to view your health records or to be provided with a copy of them. The maximum permitted charges are set out below:

To provide you with a copy of your health record the costs are:

- Health records held totally on computer: up to a maximum of £10
- Health records held in part on computer and in part manually: a maximum of £10
- Health records held manually: up to a maximum of £10 unless the records have been added to in the last 40 days in which case viewing should be free

All the above maximum charges include postage and packaging costs.

Your Data

The Data Controller is not obliged to comply with your access request unless they have sufficient information to identify you and to locate the information held about you.

In some circumstances, the Act permits the Data Controlled to withhold information held in your health record. These rare cases are:

- Where it has been judged that supplying you with the information is likely to cause serious harm to the physical or mental health or condition of you, or any other person, or
- Where providing you with access would disclose information relating to or provided by a third person who had not consented to the disclosure, this exemption does not apply where that third person is a clinician involved in your care.

Making an Access Request

Please ask at Reception for an access form entitled Application for Access to Medical Records.

Ensure that the form is fully completed, using a separate sheet of paper if necessary, and return it together with the appropriate fee.

When making your request for access, it would be helpful if you could provide details of the time-periods and aspects of your health record you require.

If you are using an authorised representative, you need to be aware that in doing so they may gain access to all health records concerning you, which may not all be relevant. If this is a concern you should inform your representative of what information you wish them to specifically request when they are applying for access.

Once the Data Controller has all the required information, and fee (where relevant), your request should be fulfilled within 21 days (in exceptional circumstances where it is not possible to comply within this period you will be informed of the delay and given a timescale for when your request is likely to be met). There is no facility for immediate access.

If you have any complaints about any aspect of your application to obtain access to your health records, you should first discuss this with the clinician concerned. If this proves unsuccessful, you can make a complaint through the NHS Complaints Procedure by contacting the Practice formally.

Cont/over.....