**Cliftonville Medical Practice**

59-61 Cliftonville Road

Belfast

BT14 6JN

Telephone: 02890 747361

**Dr ES Curran Dr S Sweeney**

**Practice opening hours:**

**8.30am-5.00pm (Mon-Fri)**

**Closed daily 1.00pm-2.00pm**

[**www.cliftonvillemedicalpractice.co.uk**](http://www.cliftonvillemedicalpractice.co.uk)

**Access to Notes (subject access request)**

This form is to request access to your patient record.

This service has no fee. However, if requests for your record are excessive or manifestly unfounded, a reasonable fee for the administrative cost will be charged to comply with the request.

We appreciate your help in completing this form.

We will act on this subject access request without undue delay and at the latest within twenty eight days of receipt.

Should we require more time to complete the request, we will be in touch as soon as possible.

**Section 1 - Details of Patient Record Required**

|  |  |
| --- | --- |
| **FULL NAME** |  |
| **DOB** |  |
| **ADDRESS** |  |
| **NHS NUMBER** *(if known)* |  |
| **CONTACT NUMBER** |  |
| **EMAIL ADDRESS** |  |
| **SIGNATURE** |  |

**Section 2- Who is Applying for Access**

**Please tick the appropriate box below:**

|  |  |
| --- | --- |
| **I am applying to access my health record***(Skip to Section 4)* |  |
| **I have instructed my authorised representative to apply on my behalf** |  |

**Section 3 - Details of Authorised Representative**

|  |  |
| --- | --- |
| **FULL NAME** |  |
| **DOB** |  |
| **ADDRESS** |  |
| **NHS NUMBER** *(if known)* |  |
| **CONTACT NUMBER** |  |
| **EMAIL ADDRESS** |  |
| **SIGNATURE** |  |

**Section 4 – Type of Access**

**Please circle if you wish to view your record or receive a hard copy:**

**VIEW ONLY HARD COPY**

**Section 5 – Information Required**

You do not have to give a reason for applying to access your health records.

However, to help the Practice save time and resources, it would be extremely helpful if you could provide details below, informing us of:

* Periods of time required
* Specific parts of your health record you require, along with details which you may feel have relevance.

*E.g. consultant name, location, written diagnosis and reports etc.*

**Please use the space below to document and continue on another page if necessary:**

**Section 6 – Authorisation**

You will be contacted on the contact details you provided, when the record is ready for collection.

Please note you will be required to provide photo ID and sign for the record when collecting this information.

Please sign to confirm you have read and completed the entirety of this form.

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Staff Use Only:**

Name of Staff Member Who Received Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was Request Taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*E.g. in person, via email etc.*

Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_