

**APPLICATION FOR ACCESS TO MEDICAL RECORDS  
General Data Protection Regulation May 2018**

**Details of the Record to be accessed:**

|                 |               |
|-----------------|---------------|
| Patient Surname | NHS Number    |
| Forename(s)     | Address       |
| Date of Birth   |               |
| Email Address:  | Phone Number: |

**Details of the Third Party making the request, if different to above:**

|                                |                          |
|--------------------------------|--------------------------|
| Surname                        | Forename(s)              |
| Company Name (if appropriate): |                          |
| Address                        |                          |
| Telephone Number:              | Relationship to Patient: |

*Please provide copies of relevant documentation confirming relationship to patient ie copy of birth certificate proving parental responsibility, Power of Attorney, Copy of the Will, Grant of Probate, etc.*

**Please note – the information will be released to the Data Subject (Patient) only**

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Internal KAMP use only:

|                            |  |
|----------------------------|--|
| Date request received      |  |
| Request logged in Register |  |

I wish to obtain a copy of my medical record:

**Option 1:** Part of the record:

|  |                                 |
|--|---------------------------------|
| <b>I would like a copy of records between specific dates only (please give date range)</b> | From (month and Year):<br>..... |
|  | To (month and Year):<br>.....   |

**Option 2:** The entire record.

|   |  |
|---|--|
| <b>I would like a copy of all records</b> |  |
|---|--|

**Option 3:** A second copy of the information that has previously been provided by KAMP

|  |   |
|--|---|
| <b>If you have previously had a copy of your medical records, please let us know when you made this request and if you received all your records up until that point, or a specific date range</b> | Date of Previous Request:<br>.....  |
|  | Information Provided:<br>Full Record<br>Date Range (please state):<br>..... |

**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 General Data Protection Regulation 2018.

I understand that copies under option 1 and 2 will be provided free of charge, unless the volume of material is considered excessive, in which case a charge may be levied, or in extreme cases, KAMP may legitimately refuse this request.

I understand that if charges are appropriate, KAMP will inform me of these in advance, and that I can then decide not to proceed, or to proceed in a different way that avoids the charge.

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