NEXT STEP

Please complete the form overleaf and return it to the practice.

Your application should indicate particular periods and/or parts of your records that you require access to. E.G. if you would like records from a certain date to a certain date.

Once we have all the relevant information we will try to comply with your request within 28 days.

In exceptional circumstances, if it is not possible to comply within the 28 day maximum period, you will be informed.

Brough Surgery
4 Centurion Way
Brough
HU15 1AY

South Cave Surgery
67 Ferry Road
South Cave
HU15 2JG

Holme On Spalding Moor Surgery
Rush View
Holme On Spalding Moor
YO43 4BJ

Bubwith Surgery
Highfield Road
Bubwith
YO8 6LY

Hessle Surgery
The Grange Hessle Primary Care Centre
11 Hull Road, Hessle
HU13 9LZ

www.theridingsmedicalgroup.nhs.uk
The Ridings Medical Group
theridingsmedicalgroup@nhs.net
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The Ridings
Medical Group
Caring for our community

Patient Leaflet

A Guide to the ACCESS OF YOUR OWN MEDICAL RECORDS

INTRODUCTION

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

Under the Data Protection Act 1998 you have the right to view, or receive copies of your records.

We are not obliged, under the Act, to comply with your access request, unless the Practice is satisfied of your identify (photo ID will be requested).

There are certain circumstances in which the Practice may withhold information. Access may be denied, or limited, where the information might cause serious harm to the physical or mental health, or condition of the patient, or any other person, or where giving access would disclose information relating to or provided by a third person who had not consented to the disclosure.

COST

Under the new GDPR regulations subject access requests are free of charge.

We would recommend that patients register for online access to their records in the first instance to see if the information they are looking for is available through Systmonline.

It is practice policy for us to send copies of your record electronically via email. We will confirm the email address with you prior to sending the electronic records. We would advise against sharing this document with Insurance companies as your medical record can be very detailed.

Full Name (Please print)

……

Current Address

……

……

Contact Tel No……

Date of Birth ……

I, the above named, wish to view /would like copies of my health
records (delete as appropriate).
I give consent for the information to be sent to the below email address electronically.

Signed ……

Date ……..

Specific dates / consultant / report

……

……

Email address for record to be sent to:

……..