LOCKWOOD SURGERY

PATIENT ACCESS DATA REQUEST

Name:	**NHS Number:**
Daytime telephone number:	
Email:	
Address:	
By completing this form, you are making a request under the General Data Protection Regulation (GDPR) for information held about you by the practice that you are eligible to receive.	
Required information (and any relevant dates):	
By signing below, you indicate that you are the individual named above. The practice cannot accept requests regarding your personal data from anyone else, including family members. We may need to contact you for further identifying information before responding to your request. You warrant that you are the individual named and will fully indemnify us for all losses, cost and expenses if you are not. Please return this form to Amy Holcroft or Casey Hancock (DC Officer and PM Manager) Please allow [*28*] days for a reply.	
Patient signature:	
Date:	

****Please ensure you read the attached information and fully informed about your request.**

Declaration (please delete response as appropriate):

1. I agree to my GP practice giving me access to my record online.	YES / NO
2. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.	YES / NO
3. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.	YES / NO
4. I agree that it is my responsibility to keep secure my username and passwords. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.	YES / NO

Other considerations

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.	
5. If I notice any inaccuracies with my record, I will inform the practice manager as soon as possible of any errors or omissions.	YES/NO
6. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.	YES / NO
7. I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.	YES / NO

<u>For practice use only:</u>

ID document:……Checked by:……Date:……..

Staff member authorised:……..……Date:……

Account created:…….……Date:……..