

**Kingussie and Laggan Medical Practice**  
**Access to Health Records & Requests for other personal information**

GDPR 2018, for living patients  
ACCESS TO HEALTH RECORDS ACT 1990, for deceased patients

**Section 1 - Details of person whose records are being requested.**

Surname.....  
Former Surname if  
applicable.....  
First Name (s).....  
Date of Birth.....  
Registered Address.....  
Current Address if different from  
above.....  
.....  
Postcode.....

Daytime telephone  
number.....

I received the leaflet "How to request GP Records & Other personal information"

**Section 2 – What information is required?**

- A DWP/PIP information summary report only
- A paper copy of the full record
- To view your health records
  
- A paper copy of records for date range   
From.....to.....
- A letter or statement from a GP
  
- Other (please specify below)

**Section 3**

**Please give full details of what the information will be used for**

**Section 4**

**Please use the space below for further information you feel is relevant to this application**

**Section 5 - Declaration –**

I declare that the information given by me in sections 1-4 is correct to the best of my knowledge and that I am entitled to apply for this information.

Please tick appropriate box:

- I am the patient
- I have been appointed by the court to manage the affairs of the patient and attach relevant documentation
- I am acting on behalf of the patient and the patient has completed the authorisation (section 5)
- I am the deceased patient's representative and attach confirmation of my status
- I have Welfare Power of Attorney for this patient and attach relevant documentation
- Other, specify.....

Patient or Applicant's name  
.....

Patient or Applicant's  
signature.....

Address if different from  
above.....

Daytime telephone  
number.....

**Please ignore this section if you are requesting your own health records/personal information**

**Section 6 - Patient's Authorisation**

I authorise Kingussie and Laggan Medical Practice to release the information requested

to.....  
Whom I have given consent to act on my behalf.

Signature

.....Date.....

Please return this form to:-

Administrator, SAR, Kingussie Medical Practice, Gynack Road, Inverness-shire  
PH21 1ET

Administrator, SAR, Laggan Medical Practice, Gergask Surgery, Laggan,  
Newtonmore, Inverness-shire, PH20 1AH

Remember that you will need to have your ID verified at the Practice.

**Confirmation of identity (OFFICE USE ONLY)**

**ID checked/Patient verified**

**Patient verified by**.....

**Date**.....