Primary HealthCare
7, Harper Lane, Floriana FRN 1940
dpo.phc@gov.mt

REQUEST FOR ACCESS TO PERSONAL HEALTH DATA

General Data Protection Regulation (EU) 2016/679 (GDPR).

Full name of patient: _____

ID or passport N^{o} : _____

Date of birth: _____

Postal address: _____

_____

Contact phone/mobile number(s) : _____ / _____

e-mail address *(optional)*: _____

I hereby apply to the Data Controller of Primary HealthCare:

[ ] To view the content of my health records / health centre file (in the presence of a health professional)

[ ] To have a copy made of the following parts of my health records / health centre file:

_____

_____

[ ] To have a copy of the following lab test results (specify type and dates):

_____

[ ] To have a copy of the report of the following medical imaging investigations (specify type and dates):

_____

[ ] To access other personal health data (please specify):

_____

_____

I request that copies of my records are delivered to me as follows:

[ ] I will collect them in person

[ ] They will be collected by my authorised representative

[ ] Please send them to my postal address

[ ] Please send them to my email address *(available only for electronic test results/reports)*

Data Protection Privacy Policy, Primary HealthCare (PHC) : The information collected about you will be used solely for the purpose it was collected and in accordance to the General Data Protection Regulation (EU) 2016/679 (GDPR). Please refer to our full Data Protection policy available on demand. The PHC Data Controller may be contacted at: **Primary HealthCare, 7 Harper Lane Floriana, FRN 1940. Email: dpo.phc@gov.mt.**

I, the signed below declare that the medical notes pertain to myself and I shall collect / am authorising (delete as necessary) Mr/Ms _____ I.D. _____ to collect the notes on my behalf.

Signature of patient / parents _____ _____ Date: _____

(in case of children under 16, both parents must sign and both ID Cards to be presented. See also (ii) below)

IMPORTANT - Please read below

i. This application is to be submitted to the administration personnel of the Health Centre/Department/Unit or the One Stop Shop (OSS).

ii. Both parents of children under 16 years must sign the application form otherwise he/she must provide a signed consent from the other parent or present a court order.

iii. Proof of the patient's identity (ID card, driving licence or passport) must be presented with the application.

iv. If the application and collection is made through an authorised representative (e.g. relative of a homebound infirm patient), the representative must present proof of his/her own identity in addition to that of the patient.

v. Copies are only sent to the patient's address as shown on the ID card.

vi. Copies can only be collected by the patient or their authorised representative upon presentation of the ID cards.

vii. Applications will only be processed if all the relevant details are supplied and the requirements above are met.

viii. The data provided in applications will be processed in conformance with the provisions of the Data Protection Law.

---------- **For Office use only** ----------

Name and I.D. of officer receiving application (PGP, CN, OSS officer or DPO) _____ _____

Declaration

I, the undersigned, declare that have seen and confirmed the identity of the patient / representative.

Signature _____

***

Request entertained: Yes / no (circle the correct response)

Reason **if not**: _____

_____

_____

Date the requested data has been collected: _____

By (name): _____

Signature: _____

After collection, the signed form is to be returned to: **The DPO, 7 Harper Lane Floriana FRN 1940**.

e-mail : **dpo.phc@gov.mt**

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