Primary HealthCare
7, Harper Lane, Floriana FRN 1940

REQUEST FOR ACCESS TO PERSONAL HEALTH DATA

Data Protection Act 2001

Full name of patient: _____

ID or passport Nº : _____

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)*

Signature of applicant: _____ Date: _____

(in case of child under 16, parent or legal guardian)

Details of authorised representative *(if applicable)*:

Name: _____ ID number: _____

Signature: _____ Date: _____

IMPORTANT - Please carefully read below

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

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

iii. If the application 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.

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

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

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

vii. If the applicant is not the patient himself/herself, by signing this form is declaring that he/she shall treat all the confidential data about the patient according to the Data Protection Act 2001 and will be held fully responsible for any of its misuse thereof.

viii. The data provided in applications will be processed in conformance with the provisions of the Data Protection Act 2001.

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 applicant/patient.

Signature _____

---------- *For office use only* ----------

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.