APPLICATION FOR ACCESS TO MEDICAL RECORDS (SAR)

In accordance with the UK General Data Protection Regulation (UK GDPR)

The Access to Health Records Act 1990 and Data Protection Act give patients/clients/staff or their representatives a right of access, subject to certain exemptions, to their health records. Redlands Primary Care respects the rights of individuals to have copies of their information wherever possible. Please complete this form if you wish to see your data. You will also need to provide proof of your identity. Your request will be processed within 30 calendar days upon receipt of a fully completed form and proof of identity.

Personal information collected from you by this form, is required to enable your request to be processed, this personal information will only be used in connection with the processing of this Subject Access Request.

We require proof of your identity before we can disclose personal data. Proof of your identity should include a copy of two documents such as your birth certificate, passport, driving licence, official letter addressed to you at your address e.g. bank statement, recent utilities bill or council tax bill. The documents should include your name, date of birth and current address. If you have changed your name, please supply relevant documents evidencing the change.

Under the terms of Section 7 of the Data Protection Act, Information disclosed under a Subject Access Request may have information removed; this is to ensure that the confidentiality is maintained for third parties referred to who have not consented to their information being disclosed.

Section 1: Patient details

Surname:		**Previous Surname(s):**	
Forename:		**Title:**	
Date of birth:			
Address:			
Telephone number:			
NHS number (if known):		**Hospital number (if known):**	

If you are applying to view your own records, please go to Section 2.
If you are applying to view another person's record, please go to Section 3.

Section 2: Details of the Record to be Accessed

Please tick the relevant boxes below. The more specific you can be, the easier it is for us to quickly provide you with the records requested. Record in respect of treatment for: (e.g., leg injury following a car accident).

I confirm I am the patient named above	☐
I am applying for an electronic copy of my medical record	☐
I am applying for a printed copy of my medical record	☐
I have instructed someone else to apply on my behalf and have indicated below if there are any limitations to access.	☐

Please detail below if the above access is to be limited in any way (e.g. only for test results, or only for making & cancelling appointments, or for a specified time period only)

Patient signature:		**Date:**	

Section 3: Details and Declaration of Applicant

Please complete if you are requesting access on **behalf of** the above-named patient

Surname:	
Forename:	
Date of birth:	
Address:	
Telephone number:	
Relationship to Patient	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Which of the following statements apply:

I have been asked to act by the patient and they have signed the declaration below	☐
I have full parental responsibility for the patient, the patient is under the age of 18 and: • Has consented to my making this request, or • Is incapable of understanding the request (delete as appropriate)	☐
I have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	☐
I am acting in Loco Parentis and the patient is under age sixteen, and is incapable of understanding the request/has consented to me making this request (delete as appropriate)	☐
I am the deceased person's personal representative and attach confirmation of my appointment (grant of probate/letters of administration)	☐
I have written, and witnessed, consent from the deceased person's personal representative and attach Proof of Appointment	☐
I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that (please supply your reasons below).	☐

Declaration:

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the GDPR.

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Applicant Signature:		**Date:**	

I confirm that I give permission for the Practice to communicate with the person identified above in regard to my medical records.			
Patient Signature:		**Date:**	

Section 4 – Records Required

- Under the GDPR you do not have to give a reason for applying for access to your health records.

- You will be asked to provide photographic identification if you wish to have Online Access to your medical records, even if you already have access to appointments, prescriptions etc.

- Please use this space below to inform us of certain periods and parts of the health record you may require or provide more information as requested above.

- This may include specific dates, consultant name and location, and parts of the records you require e.g., written diagnosis and reports.

I would like copy records relating to a specific condition/specific incident only (please detail below)	☐
I would like a copy of records between specific dates only (please give date range) below	☐
I would like a copy of all records	☐
We can provide your records through online access or as a paper copy. Please specify which you would prefer:	
Details:	

Section 5 - Consent for children under 16 (Gillick Competence)
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated.

If a child under the age of 16 has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this Consent Form for themselves, but may wish a parent to countersign as well.

If the child is not able to give consent for him/herself, someone with parental responsibility should do so on his/her behalf by signing this Form below.

I am the Patient/Parent/Guardian/Person with parental responsibility (delete as necessary)	
Signature:	
Full name:	
Address:	

Date:	

You will be telephoned when the copies are ready for collection or posting.

ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

- Signed and dated the form
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
- Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

For office use only:

Identification verification must be verified through 2 forms of ID

- One of which must contain a photo e.g., passport, photo driving licence or bank statement.

Where this is not available, vouching by a member of staff or by confirmation of information in the records by one of the clinicians may be used.

If this is a proxy request, where patient has capacity, both patient and proxy should provide identification as above in person.

Request received		Request refused	
Reviewed by		Request completed	
Fee (see section 6.4)		Date sent	
Comments			
Patient identity verified by		Date	
Method	☐ Photo ID or proof of residence. Type: …….. ☐ Photo ID or proof of residence. Type: …….. ☐ Vouching. By whom: …… ☐ Vouching with information in record – by whom ……		
Proxy identity verified by		Date	
Method	☐ Photo ID or proof of residence. Type: …….. ☐ Photo ID or proof of residence. Type: …….. ☐ Vouching. By whom: …… ☐ Vouching with information in record – by whom ……		