**Data Protection Act 1998 Subject Access Request**

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

**Details of the record to be accessed:**

|  |  |
| --- | --- |
| **Patient Surname** | **Date of Birth** |
| **First name** |
| **Address****Postcode** |
| **NHS Number****(If known)** |  |
| **Email address** |  |
| **Telephone number** | **Mobile number** |
| **Relationship to patient** |  |

**Declaration: I declare that the information given by me is correct to the best of my knowledge and I am entitled to apply for access to the health records referred to above under the terms of the Data Protection Act 1998.**

**Tick which of the following statements apply:**

* **I am the patient**
* **I have been asked to act on behalf of the patient by the patient and I attach the patients written authorisation**
* **I have full/shared parental responsibility for the patient and the patient is under the age of sixteen and is incapable of understanding \*the request/has consented to me making this request (\*Delete as appropriate)**
* **I am acting in Loco Parentis and the patient is under the age of sixteen and is incapable of understanding \*the request /has consented to me making this request (\*delete as appropriate)**
* **I am the deceased patients personal representative and attach confirmation of my appointment**
* **I have a claim arising from the patient’s death and I wish to gain access to information relevant to my claim on the grounds that**

**……………………………………………………………………………………………………………………………**

**(Please supply your reason)**

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**Under the Data Protection Act 1998 you do not have to give a reason for applying for**

**Access to medical records**

PATIENT/PATIENT REPRESENTATIVE TO CHOOSE **ONE** OF THREE OPTIONS:

1. I wish to access \*my online medical record/\*the online medical records of **(No charge)**

Name.………………………………………………………… Date of Birth ………………………………………………….

2. I am applying for copies of my full medical record/copies of the full medical record of

(£50 charge)

Name……………………………………………………………Date of Birth …………………………………………………..

3. I am applying for copies of records for specific dates or relating to a specific \*condition/\*incident for \*myself/\*on behalf of someone else

(You will be notified of charge once your form has been received and your ID is confirmed)

Name …………………………………………………….Date of Birth ……………………………………………………….

**(\*Please delete as appropriate) and I understand and agree with each statement below:**

**(Please tick)**

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the Practice |  □ |
| I will be responsible for the security of the information that I see or download |  □ |
| If I choose to share the information with anyone else, this is at my own risk |  □ |
| I have paid the appropriate fee |  □ |

|  |  |
| --- | --- |
| Signature | Date |

For Practice Admin use only

|  |  |  |
| --- | --- | --- |
| Identity verified by(Staff initials) | Date | Method1 form of Photo ID and 1 proof of residence □ |
| Authorised by (Admin) | Date (Admin) |
| Fee paid (If appropriate) |  |

**\*Admin Note\*** Please pass this form to the Practice secretary to process when completed