**Subject Access Request Form**

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| **Medlock Medical Practice** respects the rights of individuals to have copies of their information wherever possible. |
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| **Charges Payable:** In accordance with legislation **no fee** will be charged for your request, unless the request is manifestly unfounded or excessive, particularly if it is repetitive. **Please be aware subject access request will take ONE MONTH to be completed** |

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| **PLEASE COMPLETE IN BLOCK CAPITALS – Illegible forms will delay the time taken to respond to requests.** |
| **1.Details of patient records to be accessed (please compare one form per person)**

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| Surname : | Date of Birth : |
| Forename:  | Current Address: |
| Any former names (if applicable)  |
| Telephone Number:  | Previous Address (if applicable)Full Postcode:  |
|  NHS number (if known/relevant)  |

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| **2.** | **Details of Records to be Accessed**  |
| Records dated from  |  / / **to** / / |
| Records dated from  |  / / **to** / / |

**I (Print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** hereby authorise the [PRACTICE] to release any personal data they may h may hold relating to me to the above applicant and to whom I authorise to act on my behalf.

**Signature of patient:**

 **Date / /**

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| 3. | **Details of Applicant** (Complete if different to patients/clints/staff members details) |
| Full Name |  |
| Relationship with individual whose records have been requested  |  |
| Address to which a reply should be sent | **Postcode Tel:** |

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| **5.** | **Declaration**  |
| I declare that information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record(s) referred to above, under the terms of the Access to Health Records Act (1990) / Data Protection Act.**Please select one box below:**  I am the patient/client/staff member (data subject).  I have been asked to act on behalf of the data subject and they have completed section 4 -authorisation above. I am acting on behalf of the data subject who is unable to complete the authorisation section above (Covering letter with further details supplied).  I am the parent/guardian of a data subject under 16 years old who has completed the authorisation section above. (Please include proof such as birth certificate)  I am the parent/guardian of a data subject under 16 years old who is unable to understand the request and who has consented to my making the request on their behalf.  I have been appointed the Guardian for the patient/client, who is over age 16 under a Guardianship order (attached).  I am the deceased patient/client’s personal representative and attach confirmation of my appointment.  I have a claim arising from the patient/client’s death and wish to access information relevant to my claim (Covering letter with further details to be supplied). **Please Note:** * If you are making an application on the behalf of somebody else, we require evidence of your authority to do so i.e., personal authority, court order etc.

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| * It may be necessary to provide evidence of identity (i.e., Driving Licence).
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* If there is any doubt about the applicant’s identity or entitlement, information will not be released until further evidence is provided. You will be informed if this is the case.
* Under the terms of the Data Protection Act, requests will be responded to within 30 days after receiving all necessary information and/or fee required to process the request.
* If you are making a request under the Access to Health Records Act 1990, requests will be responded to within 40 days where no entries have been made to the patient/client’s record 40 days immediately preceding the date of this request, otherwise requests will be responded to within 21 days after receiving all necessary information and/or fee required to process the request.
* 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.
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| **Print Name**  |  | **Signed (applicant**) |  | **Date** |  |

**Please complete and send this document to:**

Medlock Medical Practice – Keppel Building Ashton Road West Failsworth M35 0AD

**Or Via email**: OLDCCG.icgmedlock@nhs.net