May 2020

Subject Access Request Form
(Request for Access to Records)

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. Roxbourne Medical Centre respects the rights of individuals to have copies of their information wherever possible.	
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.	
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. Before any further action is taken, we will contact you with details of our "reasonable administrative charges" in order to comply with your request.	

THIS FORM MUST BE COMPLETED IN BLUE OR BLACK INK AND SIGNED IN ORDER FOR US TO PROCESS YOUR REQUEST.

PLEASE COMPLETE IN BLOCK CAPITALS – Illegible forms will delay the time taken to respond to requests.	
1. Details of Patient/Clients/Staff members records to be accessed (Please complete one form per person)	
Title (Mr/ Mrs/ Ms/ Miss/ Dr)	Date of Birth
Surname	Forename(s)
Maiden Name (if applicable)	Current Address Full Postcode
Any former names (If applicable)	
Telephone Number	Previous Address (If Applicable) Full Postcode
NHS Number (If known/relevant)	
If further details are available please include in a separate covering note.	

2.	**Details of Records to be Accessed**
In order to locate the records you require please provide as much information as possible. Please list the department or services you have accessed that you require records from: i.e. PALs, complaints, continuing healthcare or Human resources etc (Continue on a separate sheet if required).	

Please provide me with a copy of all records held	
Please provide me with a copy of records between the dates specified below (please include the relevant department): **/ / to / /** **/ / to / /** **/ / to / /**	
Please provide me with a copy of records relating to the incident specified below:	
Please provide me with a copy of records relating to the condition specified below:	

3.	**Details of applicant** (Complete if different to patients/clients/staff members details)
Full Name	
Company (if Applicable)	
Relationship with individual who's records have been requested	
Address to which a reply should be sent	**Postcode:** **Tel:**

4.	**Authorisation to release to applicant** (to be completed by the patients/clients/staff member if not making their own request)

I (Print name) ____ hereby authorise Roxbourne Medical Centre to release any personal data they may hold relating to me to the above applicant and to whom I authorise to act on my behalf.

Signature of patient/client/staff member **:** __________________________________
Date: / /

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.
- It may be necessary to provide evidence of identity (i.e. Driving Licence).
- 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 21 days after receiving all necessary information and/or fee required to process the request.
- For requests 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.

Print Name:

Signed (Applicant):

Date:

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.

6.	**Proof of Identity**		
	Method by which ID is confirmed	**Option taken**	**Documents attached**
A	Attached copies of documents as noted in section 4A below	Yes/ No	If yes, please indicate here which documents have been attached
B	Countersignature (section 4B). This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided)	Yes/No	Please indicate the reason why this section was completed

6A	**Evidence** **Evidence of the patient's and/or the patient's representative identity will be required. Please attach copies of the required documentation to this application form. Examples of required documentation are:**	
	Type of Applicant	**Type of documentation**
A	An individual applying for his/her own records	One copy of identity required, e.g. copy of birth certificate, passport, driving licence, plus one copy of a utility bill or medical card, etc.
B	Someone applying on behalf of an individual (Representative)	One item showing proof of the patient's identity and one item showing proof of the representative's identity (see examples in '**A**' above)
C	Person with parental responsibility applying on behalf of a child	Copy of birth certificate of child and copy of correspondence addressed to person with parental responsibility relating to the patient
D	Power of Attorney/Agent applying on behalf of an individual	Copy of a court order authorising Power of Attorney/Agent plus proof of the patient's identity (see examples in '**A**' above)

6B	**Countersignature** **This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section may be completed if 4A cannot be fulfilled.**

I (insert full name) ………………………………………………………………………………...

Certify that the applicant (insert name) ………………………………………………………………………………

has been known to me personally as ……………………………………………… for ……………..years

(insert in what capacity, e.g. employee, client, patient, relative etc.)

and that I have witnessed the signing of the above declaration.

I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed…………………………………………………………... Date ………………………………………………………...

Name………………………………………………………..

Profession…………………………………………………………..

Address ………………………………………………………..…………………………………………………………..

………………………………………………………..……………………………………………………..……………………

Daytime telephone number …………………………………………………………..

Additional notes

Before returning this form, please ensure that you have:

a) Signed and dated this form
b)
b) Enclosed proof of your identity or alternatively confirmed your identity by a countersignature

c) Enclosed documentation to support your request (if applying for another person's records)

Incomplete applications will be returned. Please therefore ensure you have the correct documentation before returning the form to the Practice.