APPLICATION FORM FOR ACCESS TO HEALTH RECORDS (SAR)

In accordance with the General Data Protection Regulation (GDPR)

This form must be completed in blue or black ink and signed in order for us to process your request.

Section 1: Patient details

Surname		**Former name**	
Forename		**Title (i.e. Mr, Mrs, Ms, Dr)**	
Date of birth		**Address:**	
Telephone number		**Postcode:**	
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: Record requested

The more specific you can be, the easier it is for us to quickly provide you with the records requested, for example records in respect of treatment received (e.g. for leg injury following a car accident)

I am applying for access to **view** my records only	☐
I am applying for a printed copy of my medical record	☐

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below) From: To:	☐
I would like a copy of records relating to a specific condition/specific incident only (Please give details below) Condition/Incident:	☐
I would like a copy of all my electronic records (held on computer)	☐
I would like a copy of all my electronic and paper records since birth	☐

Please note it may not always be possible to supply the information in your preferred format

Section 3: Details and declaration of applicant

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

Surname		**Title**	
Forename(s)		**Address**	
Telephone number		**Postcode**	

(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)

I am applying for access to **view** the records only	☐
I am applying for a printed copy of the medical record	☐

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below) From: To:	☐
I would like a copy of records relating to a specific condition/specific incident only (please detail below) Condition/Incident:	☐
I would like a copy of all the electronic records (held on computer)	☐
I would like a copy of all the electronic and paper records since birth	☐

Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and 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 incapable of understanding the request	☐
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 person's death (please state details 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 terms of the UK Data Protection Act 2018.

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.

Signature of applicant: .... Date: ....

Section 4: Proof of identity

Under the Data Protection Act 2018 you do not have to give a reason for applying for access to your health records.

Patients with capacity and proxy nominees will be asked to provide two forms of identification one of which must be photographic identification. Please speak to reception if you are unable to provide this.

Section 5: Consent for children

If a child aged 13 or over 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.

They may wish a parent to countersign as well.

Young people aged 16 and 17 are legally competent and may therefore sign this consent form for themselves but may wish a parent to countersign as well.

If the child is under 18 and not able to give consent for him/herself, someone with parental responsibility may do so on his/her behalf by signing this form below.

I am the patient aged 13 – 18 years	
Signature	
I am the parent/guardian/person with parental responsibility (delete as necessary	
Signature	
Full name	
Address	
Date	

You will be telephoned/texted 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: to be completed by Reception

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:		

Please note you may need to be contacted by the practice for further information, or clarification about the request, if needed. Any questions? Please contact the Practice Manager on 01354 656841

What Evidence can be used for verification:

Evidence of the patient's and/or the patient's representative identity will be required. 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)

Countersignature

This section is to be completed by someone (other than a member of your family) who can vouch for your identity.

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 ....