Clerkenwell Medical Practice,
Finsbury Health Centre, Pine Street, London EC1R 0LP
Tel: 0207 833 5906

Subject Access Request Form

(if you are the Data Subject & a patient you can also get access to certain aspects of your medical record online by registering for online medical record access – ask for the form at reception - you may prefer this option)

a) **Details of the person whose information is being requested (ie the Data Subject)**
Full Name:
Date of Birth:
Address:
Post Code:
Telephone Number:

b) **Details of the person making the request (the Applicant)**
a. **Are you the data subject?**
Yes – then go to step c)
No – then fill in below
Full Name:
Role Description:
Address:
Post Code:
Telephone Number:
Please describe your relationship with the Data subject that leads you to make this request for information on their behalf:

c) Please give details of the information we hold that you would like to review. Please include date ranges (approximate dates are acceptable) & what aspects of data you require.

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d) Please provide one from each section of the following proof of identity and authorisation from the Data Subject:

a. Passport or photo driving license or birth certificate of the data subject.
b. Proof of address e.g. Utility bill (no longer than 3 months old) of the data subject.
c. Signed authorisation either
    i. If you are not the Data Subject then either
        1. a signed letter of authorisation from the data subject consenting that the named applicant can act on their behalf **AND** the extent of the data the Data Subject authorises to be released
        or
        2. Lasting Power of Attorney
    ii. If you are the Data Subject then a signature at the bottom of this Subject Access Request form.

Notes:

Clerkenwell Medical Practice will normally respond to a Subject Access Request within one calendar month of receipt. The period will not commence until Clerkenwell Medical Practice is satisfied as to the identity and authority of the applicant.

Clerkenwell Medical Practice may seek further information from the applicant as to the specific information requested. Any request for clarification will suspend the one calendar month period until the required clarification information has been received.

Please return this completed Subject Access Request (SAR) Form and any requested documentation to the address below.

Joanne Estabrook
Clerkenwell Medical Practice
Finsbury Health Centre
Pine Street
London EC1R 0LP

Signature of Applicant _____ **Date:** _____

PRINT NAME _____

Office use:

Date SAR Received:		Received by who:	
Evidence of Data Subject Identity taken:		What?	
Data Subject Signed Consent present			
SAR logged			

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