**Kingstone Surgery**

**APPLICATION FOR ACCESS TO PERSONAL INFORMATION**

**(SARS: Subject Access Request Form)**

|  |  |
| --- | --- |
| Once completed, please send this form to: | Kingstone SurgeryKingstoneHerefordHR2 9HN |

**Section 1 – Individual’s Details Requested**

|  |  |
| --- | --- |
| Individual’s full name |  |
| Previous name(s) |  |
| Date of birth |  |
| NHS Number (if known) |  |
| Applicant’s Current Address |  |
| Applicant’s Previous Address (if applicable) |  |
| Contact information – Telephone number Email address |  |

**Section 2 – Description of the information you require**

Please provide as much information as possible giving full details of the time periods you are interested in. You do not have to give a reason for applying for access to your health records. However, to help the Practice save time and resources, it would be helpful if you could provide details below, informing us of periods and elements of your health records you require, along with details which you may feel have relevance i.e. consultant name, location, written diagnosis and reports etc. Please use the space on the following page to document this information

|  |  |
| --- | --- |
| Type of Information required | Dates |
|  |  |

|  |  |
| --- | --- |
| Format of Information Required |  |
| Please detail how you wish to receive your information, i.e. paper copies- usual option- (**i.d.shown on collection in person**) or email (**i.d. will need to be verified on presentation in-person of email address**).Also stipulate if information needs to be provided in a format allows for consideration of accessibility issues. | Paper (default)Other: (please state) |
| I am applying for a copy of my recorded calls. |  |

**Section 3 – 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 personal information referred to above under the terms of the UK General Data Protection Regulation/Data Protection Act 2018/Access to Health Records Act 1990.

|  |  |
| --- | --- |
| Applicants Name |  |
| Address to which reply should be sent (if different from above) including postcode |  |
| Signature of applicant |  |

(If you are not the person named in Section 1, please tick one of the following boxes)

|  |  |
| --- | --- |
| I am the parent/guardian of an individual under 16 years old who has completed the Authorisation section (Section 4). |  |
| I am the parent/guardian of an individual under 16 years old who is unable to understand the request. |  |
| I am the deceased patient’s personal representative and attach confirmation of my appointment by a court to manage the patient’s affairs |  |
| I am the legal representative of the individual, and they have given signed authorisation (Section 4) |  |
| Other (please specify) |  |

**Section 4 – Authorisation**

I hereby authorise THE SURGERY KINGSTONE to release the requested personal data that they may hold relating to me to ………………………………………. (*Enter the name of the person acting on your behalf*), to whom I have given consent to act on my behalf.

**If you are a parent requesting child’s information you must include evidence of parental responsibility (eg copy of birth certificate).**

**Children over 11 years may be contacted by the surgery.**

Signature of Applicant……………………………….

Date………………………………….

**Section 5 – Collection**

Collection of Subject Access Request documents needs to be done in person and on presentation of i.d.

Request for emailed copies will also require i.d. verification in person before sending to the email.