



475 Stoney Stanton Road
CV6 5EA

Clay Lane Health Centre
5, Clay Lane CV2 4LJ

1 Chester St
CV1 4DH

1 Balliol Road
CV2 3DR

Email: crccg.godivagroup@nhs.net Tel: 02475096629

APPLICATION FORM FOR ACCESS TO HEALTH RECORDS IN ACCORDANCE WITH THE GENERAL DATA PROTECTION REGULATION (GDPR) DATA SUBJECT ACCESS REQUEST

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

Section 1: Patient details

Surname		Maiden Name	
Forename		Title Mr, Mrs, Ms, Dr	
Date of Birth		Address	
Telephone Number		Postcode	
NHS Number (If known)		Hospital Number (If known)	

Section 2: Record requested.

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

Please provide me with a copy of all records held.	
Please provide me with a copy of records between the dates specified below:	
Please provide me with a copy of records relating to the incident specified below:	
Please provide us the reason why do you need your medical records for?	

Dr P Bahalkar

Dr N Ali

Dr D Reddy

Dr S Xavier



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Section 3: Details and declaration of applicant.

Please enter details of applicant if different from section 1.

Surname		Title Mr, Mrs, Ms, Dr	
Forename		Address	
Telephone number		Post Code	

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 GDPR.

Please Tick:

- I am the Patient.
- I have been asked to act by the patient and attach the patient's written authorisation.
- I have full parental responsibility for the patient and the patient is under the age of 18.
and:
(A) Has consented to making this request, or
(B) 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).

Signature of applicant: Date:

You are advised that the making of false or misleading statements to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

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Section 4: Proof of Identity

Please indicate how proof of ID has been confirmed. Please select A or B:

Method in which identity is confirmed.	Option Taken	Documents attached
Attached copies of documents as noted in section 4A below	Yes/No	If yes, please indicate here which documents have been attached
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 reason why this section was completed

4A – 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 license, 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 & 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).

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Section 4B: Countersignature

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

I (insert full name) Certify that the applicant
(insert full name) has been known to me personally as
..... for years (insert in what capacity e.g., employee, client, patient,
relative etc.) and that I witness 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: **Telephone:**

Additional Notes:

Before returning these forms, please ensure that you have:

- Signed and dated this form.
- Enclosed proof of your identity or alternatively confirmed your identity by countersignature.
- Enclosed documentation to support your request (if applying on behalf of someone).

Incomplete applications will be returned, please ensure you have the correct documentation before returning the form.



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Future SARs

There are specific rules that cover repeated subject access request that we need to make you aware of.

It is important to advise that any patient who is requiring a copy of their medical records that you are sharing with solicitors or insurance company, you must request that these are returned to you as any further request that you make can be made subject to an administration fee.

- If you will already have been provided with a copy of your records, any repeated SARs will generally only cover additional information added to your record since the date of the last request.
- Any request for a further copy of full or partial records will be subject to an administration charge of up to £50.

Signed: _____

Date: _____

For office use only:

Identification verification must be verified through 2 forms of ID

- One must contain a photo, e.g., passport or photo driving licence, and a bank statement
- When 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, when the patient has capacity, both the patient and the proxy should provide identification as above in person

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Request received		Request refused	
Reviewed by		Request completed	
Fee (see section 6.5)		Date sent	
Comments			
Patient identity verified by		Date	
Method	<input type="checkbox"/> Photo ID or proof of residence – Type..... <input type="checkbox"/> Photo ID or proof of residence – Type..... <input type="checkbox"/> Vouching – by whom..... <input type="checkbox"/> Vouching with information in record – by whom.....		
Proxy identity verified by		Date	
Method	<input type="checkbox"/> Photo ID or proof of residence – Type..... <input type="checkbox"/> Photo ID or proof of residence – Type..... <input type="checkbox"/> Vouching – by whom..... <input type="checkbox"/> Vouching with information in record – by whom.....		

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