Chadsfield Medical Practice, Romiley Health Centre,
Chichester Road, Romiley, Stockport, SK6 4QR. Tel No: 0161 983 9388
www.chadsfieldmedicalpractice.co.uk

APPLICATION FOR ACCESS TO MEDICAL RECORDS: Subject Access Request (SAR)

We have received your request for access to your medical record or the medical record of someone else by yourself. Please can you complete the following and return it to us as soon as possible.

Details of the Record to be accessed:

Patient Surname:	NHS Number:
Forename(s):	Address:
Date of Birth:	

Details of the Person who wishes to access the records, if different to above:

Surname	
Forename(s):	
Address	
Telephone Number	
Relationship to Patient	

Declaration, I declare the following by signing this consent form:

- 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 current data protection laws in force within the UK.
- I understand that I have to provide photo identification in order to gain access to the above health record
- I understand that the 28- day deadline as required by law for provision of the above-mentioned record will not begin until I have provided satisfactory consent and details as required by the Practice to satisfy data protection procedures in place at Chadsfield Medical Practice
- I understand that once my records are prepared if I wish to collect them in person or via a named representative, they will need to be signed for and photo identification shown upon collection to ensure safety.
- If I cannot collect my records in person, I will let the Practice know so that alternative delivery can be arranged
- If I wish for my records to be sent via email, I understand that proof of my identity will be sought via security questions and / or photo ID and it is the Practices responsibility to ensure this is satisfactory
- If I wish for my records to be sent via email, I understand that I must provide a secure email address below
- I understand the Chadsfield Medical Practice is not responsible for the security of my data once it has been disclosed to me or my named representative and I take full responsibility for this by signing this consent form
- I understand that my request may be refused if the Practice has a lawful basis to do so and that I will be informed if this is the case

Please tick whichever of the following statements apply.

- ☐ I am the patient
- ☐ I have been asked to act by the patient and attach the patient's written authorisation
- ☐ I am acting in Loco Parentis and the patient is under age _____ , and is incapable of understanding the request* / has consented to me making this request*.
  (*delete as appropriate)
- ☐ I have a claim arising from a patient's death and wish to access information relevant to my claim on the grounds stated (please supply your reasons below)

_____

_____

Patient / Representative Signature:

..... **Date:** **.....**

Patient to complete **Details of Application** (please tick as appropriate)

I am applying for access to view my records only and understand this will be via appointment only	
I am applying for copies of my medical record From: _____ to: _____	
I have instructed someone else to apply on my behalf	
I am requesting electronic information relating to the following dates From: _____ to: _____	
For email requests I confirm that my email address is secure **Enter email address**:	

Notes:

You do not have to give a reason for applying for access to your own health records

Please use this space to inform us if the information you require relates to specific conditions or periods of treatment only – or anything else as you see fit:

_____

_____