Updated 1.9.19 MD
Review by 1.9.20

Subject Access Request for Access to Records

The Access to Health Records Act 1990 and Data Protection Act give patients/clients/staff a right of access, subject to certain exemptions, to their health records. Morrab Surgery respects the rights of individuals to have copies of their information wherever possible.
Personal information collected from you by this form, is required to enable your request to be processed, this personal information will only be used in connection with the processing of this Subject Access Request.
Charges Payable: In accordance with legislation, **no fee** will be charged for your request, unless the request is manifestly unfounded or excessive, particularly if it is repetitive. Before any further action is taken, we will contact you with details of our "reasonable administrative charges" in order to comply with your request.

PLEASE COMPLETE IN BLOCK CAPITALS – Illegible forms will delay the time taken to respond to requests	
1.	**Details of Patient/Client/ records to be assessed** (please complete one form per person)
Surname:	**Date of Birth:**
Forename(s):	**Current Address:** **Full Postcode:**
Any former names (if applicable):	**Previous Address (if applicable):** **Full postcode:**
Telephone Number:	**NHS Number (if known/relevant):**
If further details are available, please include in a separate covering note.	

2.	**Details of Records to be Accessed**	
In order to locate the records you require, please provide as much information as possible. Please state any specific secondary care departments information needed (if this is recorded in your Primary care records) i.e. hospital correspondence, counselling correspondence etc. If all records are requires please complete section 2a.		
Records dated from		**Department or services accessed**
/ / to / /		
/ / to / /		
/ / to / /		
2a.	**Full records request**	
I Require a full and complete Medical Record for the above Patient/Client		**YES / NO**

3.	**Details of Applicant completing this form.**
Full Name:	
Company (if applicable):	
Relationship with individual who's records have been requested:	
Address to which a reply to this request should be sent	**Postcode:** **Tel:**

4.	**Authorisation to release to applicant** (to be completed by the patient/client if not making their own request)

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I (print name)_____ hereby authorise Morrab Surgery to release any personal data they may hold relating to me to the above applicant and to whom I authorise to act on my behalf.

Signature of Patient/Client _____ **Date: / / to / /**

5.	**Declaration**

I declare that information given to me is correct to the best of my knowledge and that I am entitles to apply for access to the health record(s) referred to above, under the terms of the Access to Health Records Act (1990)/ Data Protection Act.

Please select one box below:

□ I am the patient/client (data subject)

□ I have been asked to act on behalf of the data subject and they have completed section 4 –authorisation above.

□ I am acting on behalf of the data subject who is unable to complete the authorisation section above (Covering letter with further details supplied).

□ I am the parent/guardian of a data subject under 16 years old who is unable to understand the request and who has consented to my making the request on their behalf.

□ I have been appointed the Guardian for the patient/client, who is over age 16 under a guardianship order (attached)

□ I am the deceased patient/Client's personal representative and attach confirmation of my appointment.

□ I have a claim arising from the parent/ client's death and wish to access information relevant to my claim (covering letter with further details to be supplied)

Please note:

- If you are making an application on behalf of somebody else, we require evidence of your authority, court order etc.
- It will be necessary to provide evidence of identity. **Two separate original documents from below:**
  - **Photo ID:** driving licence, passport
  - **Proof of Current Address:** bank statement, credit card statement, utility bill
  - **Proof of Parental Responsibility if accessing a child's medical records** (please ask if this applies to you)
- If there is any doubt about the applicant's identity or entitlement, information will not be released until further evidence is provided. You will be informed if this is the case.
- Under the terms of the Data Protection Act, requests will be responded to within 40 days where no entries have been made to the parent/ client's record 40 days immediately preceding the date of this request, otherwise requests will be responded to within 21 days after receiving all necessary information and/or fee required to process the request.
- Under the terms of Section 7 of the Data Protection Act, information disclosed under a Subject Access Request may have information removed; this is to ensure that the confidentiality is maintained for third parties referred to who have not consented to their information being disclosed.

Print Name		**Signed (Applicant)**		**Date**	**/ /**

PLEASE BRING THIS COMPLETED FORM WITH YOUR 2 DOCUMENTS OF PROOF OF IDENTITY TO THE SURGERY FOR THE ATTENTION OF THE DEPUTY PRACTICE MANAGER.

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Office Use ONLY:

Documents Verified: Please list here _____

Date:_____ SIGNATURE OF VERIFYING MEMBER OF STAFF _____

1st Form of ID: _____

2nd Form of ID: _____