

**Subject Access Request Form**

The Practice respects the rights of individuals to have copies of their information wherever possible.

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| --- | --- |
| **Details of Patient** | |
| **Title** | Mr Mrs Miss Ms Dr |
| **Surname** |  |
| **Forename(s)** |  |
| **Any former names**  **(If Applicable)**  **E.g. Maiden Name** |  |
| **Date of Birth** |  |
| **NHS Number**  **(If known/relevant)** |  |
| **Current Address**  **Postcode** |  |
| **Home Number** |  |
| **Mobile Number** |  |
| **Email** |  |
| **Signature** |  |
| **Date** |  |

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

Please note that you might be contacted by the Practice for further information, or clarification about the request.

**Record to be Accessed**

The more specific you can be, the quicker we can be to provide you with the records requested.

|  |  |
| --- | --- |
| ***Option 1:* Please provide me with a copy of all my electronic records held** |  |
| ***Option 2:* Please provide me with a copy of my electronic records between the dates specified** | **Start Date:**  **End Date:** |
| **Records Dated from** | **Name of Department or Services Accessed** |
| **/ / to / /**  **/ / to / /** |  |
| ***Option 3:* Please provide me with a copy of records relating to a specific condition or incident :( Or you can ask for access to just your consultations, documents, past medications etc.)** |  |
| ***Option 4:* Please provide me with a copy of all my electronic records and paper records held *(please be aware there may be a small admin fee for this service due to the excessive work required)*** |  |
| **Please select how you would like to receive your subject access request once completed** | **Via**   * **Secure Email** * **Online Services (NHS/Patient Access App)** * **Print Out to Collect from The Surgery** |

**Declaration**

I confirm that the information that I have supplied in this application is correct, and I am the person to whom it relates.

I declare that information given by me is correct to the best of my knowledge and that I am entitled 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.

|  |  |
| --- | --- |
| **Name** |  |
| **Signature** |  |
| **Date** |  |

* Under the terms of the Data Protection Act, Subject Access Requests will be responded to within 30 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.

**Please complete & send this document to:**

Dated: April 2024

Review: As per FPM update

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Version: 2.0

[Sxicb-bh.thehaven@nhs.net](about:blank)