Oldwood Surgery
& Battle Health Centre

APPLICATION FOR ACCESS TO MEDICAL RECORDS SUBJECT ACCESS REQUEST (SAR)

In accordance with the UK General Data Protection Regulation (UK GDPR)

Section 1: Patient details

Surname		**Former name**	
Forename		**Title**	
Date of birth		**Address:**	
Telephone number		**Postcode:**	
NHS number (if known)		**Hospital number (if known)**	

If you are applying to view your own records, please go to Section 2.

If you are applying to view another person's record, please go to Section 3.

Section 2: Record requested

Please tick the relevant boxes below. 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)

I am applying for access to **view** my records only	☐
I am applying for an electronic copy of my medical record	☐
I do not have an email address – please contact me to discuss options	☐

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below)	☐
I would like a copy of records relating to a specific condition/specific incident only (please detail below)	☐
I would like a copy of all my electronic records (held on computer)	☐
I would like a copy of all my electronic and paper records since birth	☐

Patient signature		**Date**	

Section 3: Details and Declaration of Applicant

Please complete if you are requesting access on **behalf of** the above-named patient

Surname		**Title**	
Forename(s)		**Address**	
Telephone number			
Relationship to patient		**Postcode**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

I am applying for access to **view** the records only	☐
I am applying for an electronic copy of the medical record	☐
I do not have an email address – please contact me to discuss options	☐

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below)	☐
I would like a copy of records relating to a specific condition/specific incident only (please detail below)	☐
I would like a copy of all the electronic records (held on computer)	☐
I would like a copy of all the electronic and paper records since birth	☐

Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and the patient is under the age of 18 and: • Has consented to my making this request, or • 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)	☐

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 UK Data Protection Act 2018.

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

Applicant signature		**Date**	

I confirm that I give permission for the organisation to communicate with the person identified above regarding my medical records			
Patient signature		**Date**	

Section 4: Proof of identity

Under the Data Protection Act 2018 you do not have to give a reason for applying for access to your health records.

Patients with capacity and proxy nominees will be asked to provide two forms of identification one of which must be photographic identification. Please speak to reception if you are unable to provide this.

Section 5: Consent for children

If a child aged 13 or over has "sufficient understanding and intelligence to enable him/her to understand fully what is proposed" (known as Gillick Competence), then s/he will be competent to give consent for him/herself. They may wish a parent to countersign as well.

Young people aged 16 and 17 are legally competent and may therefore sign this consent form for themselves but may wish a parent to countersign as well.

If the child is under 18 and not able to give consent for him/herself, someone with parental responsibility may do so on his/her behalf by signing this form below.

I am the patient aged 13 – 18 years	
Signature	
I am the parent/guardian/person with parental responsibility (delete as necessary)	
Signature	
Full name	

Address	
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

Request received		Request refused	
Reviewed by		Request completed	
Fee (see section 6.5)		Date sent	
Comments			
Patient identity verified by		Date	
Method	☐ Photo ID or proof of residence – Type …….. ☐ Photo ID or proof of residence – Type …….. ☐ Vouching – by whom …… ☐ Vouching with information in record – by whom ……		
Proxy identity verified by		Date	
Method	☐ Photo ID or proof of residence – Type …….. ☐ Photo ID or proof of residence – Type …….. ☐ Vouching – by whom …… ☐ Vouching with information in record – by whom ……		