# Annex A – Application for access to medical records (SAR)

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

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Previous name** |  |
| **Forename** |  | **Title** |  |
| **Date of birth** |  | **Tel number** |  |
| **Address** |  | **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.

|  |  |
| --- | --- |
| I am applying for an electronic copy of my medical record | 🞏 |
| I am applying for a printed copy of my medical record | 🞏 |

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)** |  | **Relationship to patient** |  |
| **Address** |  | | |
| **Postcode** |  | **Telephone number** |  |

(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 an electronic copy of the medical record | 🞏 |
| I am applying for a printed copy of the medical record | 🞏 |

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 13 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 [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted).

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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant signature** |  | **Date** |  |

I confirm that I give permission for the practice 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](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) 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 is under 13 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 under 16 years** | |
| **Signature** |  |
| **I am the parent/guardian/person with parental responsibility (delete as necessary)** | |
| **Signature** |  |
| **Full name** |  |
| **Address** |  |
| **Date** |  |

You will be telephoned when the copies are ready for collection.

**ADDITIONAL NOTES:**

Before returning this form, please ensure that you have:

* Signed and dated the form
* Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
* Enclosed documentation to support your request (if applicable)

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