**PATIENT NOTE: As stated by law, SARs may take up to 28 days to process.**

**The Good Practice Data Subject Access Request (SAR)**

**PLEASE INDICATE WHICH FORMAT YOU WOULD LIKE YOUR RECORDS IN:** ELECTRONIC/PAPER

This form must be completed in black ink and signed in order for us to process your

request.

**Section 1: Patient details**

|  |
| --- |
| **DATE SUBMITTED (MANDATORY OTHERWISE FORM WILL NOT BE PROCESSED):**dd/mm/yyyy |
| **Surname** |  | **Maiden name** |  |
| **Forename** |  |

|  |
| --- |
| **Title**  |
| **(i.e. Mr, Mrs, Ms, Dr)**  |

 |  |
| **Date of birth** |  | **Address:** |  |
| **Telephone number** |  | **Postcode:** |  |
| **NHS number (if known)** |  | **Hospital number (if known)** |  |

**Section 2: Record requested**

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)

|  |  |
| --- | --- |
| **Please provide me with a copy of all records held** |  |
| **Please provide me with a copy of records between the dates specified below:** |  |
| **Please provide me with a copy of records relating to the incident specified below:** |  |
| **Please provide me with a copy of records relating to the condition specified below:** |  |

**Section 3: Details and declaration of applicant**

Please enter details of applicant if different from Section 1

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Title** **(Mr, Mrs, Ms, Dr)** |  |
| **Forename(s)** |  | **Address** |  |
| **Telephone number** |  | **Postcode** |  |

**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 GDPR.

Please tick:

 I am the patient

 I have been asked to act by the patient and attach the patient’s written authorisation

 I have full parental responsibility for the patient and the patient is under the age of 18

 and:

1. has consented to my making this request, or
2. 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)

Signature of applicant: ...................................................... Date: ………………………..

**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.**

**Section 4: Proof of identity**

Please indicate how proof of ID has been confirmed. Please select ‘A’ or ‘B’:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Method in which identity is****confirmed** | **Option taken** | **Documents attached** |
| A  | Attached copies of documents asnoted in section 4A below | Yes/No | If Yes, please indicate here which documents have been attached |
| B  | Countersignature (section 4B). This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided) | Yes/No | Please indicate reason why this section was completed |

**4A – Evidence**

**Evidence of the patient’s and/or the patient’s representative identity will be required. Please attach copies of the required documentation to this application form. Examples of required documentation are:**

|  |  |  |
| --- | --- | --- |
|  | **Type of applicant** | **Type of documentation** |
| **A** | An individual applying for his/herown records | One copy of identity required,e.g. copy of birth certificate, passport, driving licence, plus one copy of a utility bill or medical card, etc. |
| **B** | Someone applying on behalf of anindividual (Representative) | One item showing proof of the patient’s identity and one item showing proof of therepresentative’s identity (see examples in ‘**A’** above) |
| **C** | Person with parental responsibilityapplying on behalf of a child | Copy of birth certificate of child & copy of correspondence addressed to person with parental responsibility relating to the patient |
| **D** | Power of Attorney/Agent applying on behalf of an individual | Copy of a court order authorising Power of Attorney/Agent plus proof of the patient’s identity (see examples in ‘**A’** above) |

**4B – Countersignature**

**This section is to be completed by someone (other than a member of your family) who**

**can vouch for your identity. This section may be completed if 4A cannot be fulfilled.**

I (insert full name).................................................................................................................

Certify that the applicant (insert name).................................................................................

Has been known to me personally as .......................................... for ..........................years

(Insert in what capacity, e.g. employee, client, patient, relative etc.)

and that I have witnessed the signing of the above declaration. I am happy to be contacted if

further information is required to support the identity of the applicant as required.

Signed ................................................................................Date .........................................

Name ................................................................... Profession. .............................................

Address ................................................................................................................................

...............................................................................................................................................

Daytime telephone number .................................................................................................

**Additional notes**

Before returning this form, please ensure that you have:

1. signed and dated this form

b) enclosed proof of your identity or alternatively confirmed your identity by a countersignature

c) enclosed documentation to support your request (if applying for another person’s records)

Incomplete applications will be returned; therefore please ensure you have the correct

documentation before returning the form.

Form to be brought to Reception with identity documents or can be emailed, with scanned copies of ID to – thegoodpractice2@nhs.net

EXPEDITED SUBJECT ACCESS REQUESTS CAN BE REQUESTED IN EXCEPTIONAL CIRCUMSTANCES, PLEASE ENQUIRE WITH OUR ADMINISTRATIVE TEAM.