

**Subject Access Request Form & Access to Medical Records  
The Marshside Surgery**

**Details of the Record to be Accessed:**

Patient Surname:	NHS Number: (if Known)
Forename(s):	Address:
Date of Birth:	

**Details of the Person who wishes to access the records, if different to above:**

Surname:	
Forename(s):	
Address:	
Telephone Number:	
Relationship to Patient:	

Delete as appropriate;

**Requests made to access the records of living persons**

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.

**Requests made to access the records of deceased persons**

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 Access to Health Records Act.

Tick whichever of the following statements apply.

- I am the patient
- I have been asked to act by the patient and attach the patient's written authorisation
- I am acting in Loco Parentis (in place of the parent) and the patient is under age 13, and is incapable of understanding the request / has consented to me making this request.  
(\*delete as appropriate).
- I have a claim arising from the patient's death and wish to access information relevant to my claim  
(please supply your reasons below).

**Applicant signature.....Date.....**

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**Details of Application - Patient to complete**

**(please tick as appropriate)**

I am applying for access to view my records only	
I am applying for copies of my medical record	
I have instructed someone else to apply on my behalf	

**Notes:**

Under the Data Protection Act 2018 you do not have to give a reason for applying for access to your health records. Under the Access to Health Records Act you will/will not need to give reasons for applying for access to a deceased person's health records.

You **will** be asked to provide photographic identification.

**Optional** - Please use this space below to inform us of certain periods and parts of your health record you may require or provide more information as requested above.

This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports. If this is a repeated requested within sixty days or an excessing request there may be a charge.

I would like a copy of all records	
I would like a copy of records between specific dates only (please give date range) below	
I would like copy records relating to a specific condition / specific incident only (please detail below)	

Up to here:

I wish to access my medical record online and understand and agree with each statement (please tick)

I have read and understood the information on the reverse of this form	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	<input type="checkbox"/>

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**To be completed by Practice staff:**

Name of authorising Clinical Lead:	
Clinical Lead has checked that there is any 3rd Party data in the notes has been redacted:	
Date authorisation obtained from Clinical Lead:	
Staff Member dealing with request:	
Date notes made available to patient:	
Date notes were sent out by recorded delivery and by who (if applicable):	
Date notes were collected by patient and signed for with ID verified (if applicable):	

**If notes Collected by patient:**

Name of Patient:	
Address of patient:	
DOB of patient:	
Signature of patient & date:	
ID verified by: Please make a note of the type of verification documents you have seen:	
Signature of member of staff who verified ID and the date:	