Application form for access to Medical Records...

This form meets with General Data Protection regulation and acts as a Data Subject Access Request (DSAR)

This form must be completed in Blue or Black Ink

Section 1: Patient Details

Surname		Maiden Name	
Forename		Title	
Date of Birth		Address	
Telephone Number		Postcode	
NHS Number		Hospital Number	

Section 2: Reason Requesting Medical Records

Please briefly describe the reason you are requesting these records.

Section 3: Details of records you are requesting (please tick one box)

The more specific you can be, the easier it is for us to quickly provide you with the records requested. E.G if you are requesting information for a specific injury or illness and know the dates please provide this information.

Please provide me with a copy of all Medical Records held at the practice	
Please provide me with a copy of all records between the dates specified below:	

Please provide me with a copy of records relating to the above specified incident:	
Please provide me with a copy of records relating to the condition specified below	

Section 4: Details of Applicant

Please give details of the person who is applying for access to the above records

Surname		**Title**	
Forename(s)		**Address**	
Telephone Number		**Postcode**	

Section 5: Proof of identity

Please provide the relevant identification as listed below for applicants

Type of Applicant	**Type of Documentation**
An Individual applying for his/her own records	**One** copy of identity required Either: Copy of Birth Certificate Driving Licence **One** copy of a Utility Bill
A representative of the Individual	**One** item showing proof of the patients identity **One** item showing proof of the representatives identity **One** copy of a utility bill for both the patient and representative
Person with Parental Responsibility applying on behalf of a Child	**One** copy of Childs Birth Certificate **One** copy of identity for the person with Parental responsibility **One** utility bill addressed to the person with Parental Responsibility
Power of Attorney/ Agent applying on behalf of an individual	**One** copy of a court order authorising Power of Attorney/Agency **One** item showing proof of the patients identity.

Section 6: Countersignature

This section can be completed by someone other than a family member who can vouch for your identity if you are unable to provide the documents requested in the proof of identity section.

I (person vouchings name) ____

Certify that the applicant (Applicants Name) _________________________________

Has been known to me personally as _____________________ for __________years
(please insert the capacity that you know the applicant)

I have witnessed the signing of the above declaration and am happy to be contacted if you require further information to support the identity of the applicant

Signed ___________________________________

Date _______________

Name _______________________

Profession ______________________

Address ____

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Daytime Telephone Number ______________________