WILLOWFIELD SURGERY

Data Subject Access Request/Access to Health Records

Personal information collected from you by this form, is required to enable your request to be processed, this personal information will only be used in connection with the processing of this Subject Access Request/Access to Health Records

Charges Payable: In accordance with legislation no fee will be charged for your request, unless the request is manifestly unfounded or excessive, particularly if it is repetitive. We will then contact you with details of our 'reasonable administrative charges' in order to comply with your request.

Section 1: Patient details – Please complete in block capitals

Surname	**Date of Birth**
Forename(s):	
Any former names (if applicable)	

Daytime telephone number _____

Mobile number _____

I give permission for Willowfield Surgery to contact me on the above number/s and leave a voicemail if I am not available at the time. **YES NO**

Signature: _____

Current Address: _____

_____

Full Postcode: _____

NHS number (if known)

Section 2: Record Requested *(Code: 8MA.00 Patient requests copy of medical record)*	
By completing this form, I am making a request under the General Data Protection Regulation (GDPR) for information held about me by the practice that I am eligible to receive. I understand that the whole of my medical record or records held between specific dates requested including correspondence, test results and details of every consultation will be made available to me to collect from Willowfield Surgery.	
The reason for my request is *(continue on another page if necessary)*	
Please provide me with a copy of all my records held	YES /NO
Please provide me with a copy of my records held between these specific dates	From To
Please provide me with a copy of my records relating to the incident specified below:	
Please provide me with a copy of my records relating to the condition specified below:	
Section 3: Details and declaration of applicant	
By signing below, I indicate that I am the individual named above and that the information given be me is correct to the best of my knowledge. I understand that all records must be collected in person from Willowfield Surgery. I understand the practice cannot accept requests regarding my personal data from anyone else; including family members unless requested in writing by myself and photographic ID must be presented upon collection by me or my named person. I understand my medical records may include third party/documents relating to me. I understand the practice team may need to contact me for further identifying information before responding to my request. I warrant that I am the individual named and will fully indemnify Willowfield Surgery for all losses, cost and expenses if I am not. 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.

Data subject's signature:	**Date:**

Section 4: Authorisation for a named person to collect my medical records *(Code: 9NdG.00 – Consent given to share patient data with specified third party))*

I, _____ (Patient name) authorise _____

my, _____(relationship to you) _____ to collect the medical records I requested from the practice and they are aware that photographic ID must be produced when collecting or the surgery retain the right not to relinquish the records.

Section 5: Collection of requested records *(Code: 9Ndi.00 – Consent given)*

I confirm I have collected a copy of my/_____ medical records as requested and authorised by me/them. I take full responsibility for the safe keeping of the documents received from the surgery once I have signed for them and taken them off the Practice premises.

Patient Name: _____ Date: _____

OR

Named person signature: _____ Date: _____

Relationship to Patient: _____

Proof of identity/Evidence:

Copy of birth certificate, passport, driving licence YES/NO

One copy of a utility bill or medical card YES/N0

I understand that the making of false or misleading statements in order to obtain personal information to which I am not entitled is a criminal offence which could lead to prosecution.

Staff member signature: _____ Date: _____

Office only: Scan ID and form to patient's journal. Make entry on journal using specific codes detailed.

Please return this form to a member of the Willowfield Surgery reception team. Please allow 28 days for a reply.