**Request to Access Personal Records**

***PRIVATE AND CONFIDENTIAL***

**SAR1** Subject Access Request

General Data Protection Regulation (EU) 2016/679 and Data Protection Act

The form should be filled out in block capitals or in type.

**Section 1: Details of person whose records are being requested**

|  |  |
| --- | --- |
| Surname: |  |
| Former Surname: |  |
| First names: |  |
| Title: | Mr/Mrs/Ms/Miss/Other |
| Date of Birth: |  |
| NHS Number: |  |
| Current Address: |  |
| Former Address : (if applicable) |  |

**Section 2: Applicant details (if making a request on behalf of the person above)**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Relationship to person in section 1: |  |

**Section 3a: Records to be released**

I understand that filling in and signing this form gives you permission to release copies of the following GP records to the person whose details are given above:

Please tick **one**:

* Full electronic record
* Full electronic record + old paper notes (please bear in mind that this option will take a few weeks longer as we need to request your notes from our off-site unit and then copy them)

**Section 3b:**

Please tick **one**:

* Full copy of my records
* Records for the period from …………………………….. to ………………………….

**Section 4: Consent**

Please tick **one** of following boxes and sign below:

|  |  |
| --- | --- |
| I confirm I am the person mentioned in section 1 and I require access to my  personal records. I will collect these from Saltash Health Centre | ☐ |
| I confirm I am the person mentioned in section 1 and I authorise the release of  copies of my personal records (described in section 3) to the person mentioned in  section 2. | ☐ |
| I confirm that I am the person mentioned in section 2 and I have parental  responsibility for the child in section 1. I will collect these from Saltash Health Centre. | ☐ |
| I confirm I am the person mentioned in section 2 and have been authorised to an  act as an agent/power of attorney for the patient in section 1. I will collect these from Saltash Health Centre. | ☐ |

|  |  |
| --- | --- |
| Name: | PLEASE WRITE NAME IN CAPITALS |
| Signature: |  |
| Date: |  |