

Higham Ferrers Surgery

SUBJECT ACCESS REQUEST FORM (SAR)

Information

You will appreciate that health data relating to any individual is highly confidential and the Practice must ensure that it releases such data only to the person to whom it relates, or to a person authorised to act on his or her behalf. If you require to see any health data, please complete this online Request Form as fully and accurately as possible to enable us to locate the exact information you require.

The General Data Protection Regulations (GDPR) gives you the statutory right of access to any information, manual (paper) or computerised. You may wish to authorise someone else to make your application on your behalf and if you have parental responsibilities you may make an application to see your child's notes.

You do not have to give a reason for applying for access to your General Practice records. If you do not need access to your entire records, it would be helpful if you would inform us of the periods and area of your health records that you require, along with details which you feel may have relevance (e.g. clinic type, location, dates).

Timescale

The Practice will deal with your request as quickly as possible. The information should be available to you within 28 days of receipt of your accurately completed form and confirmation of consent. Under certain circumstances, this period can be extended to 3 months but we will keep you informed of the progress of your request during this extended period.

Fees

We will not make a charge for the first request for access to your medical records. We may, however, charge for subsequent requests or if we deem that the volume of information requested is excessive. You have the right to simply view your records (i.e. not receive a copy in a permanent form); information on how to arrange this is detailed below.

Type of request

If you request to see the original records, you will be invited to make an appointment at a mutually convenient time to view them. If you request copies, these will be ready within the allocated timescales specified by the Regulations, and we will telephone you when they are available for you to come to the Practice to collect them.

Proof of identity

Two forms of identity must be provided (one of which must be photographic). This is to ensure information is not released to unauthorised individuals. The table below outlines the proof of identity we can accept.

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TYPE OF APPLICATION	IDENTIFICATION REQUIRED
<p>Patient applying for their own <i>Can be waived if the applicant is known to the Staff Member accepting the request</i></p>	<ul style="list-style-type: none"> • One which must be photographic i.e. passport. • One containing individuals name and address
<p>Third Party Applying. <i>Consent of Patient will be required BEFORE the request will be processed</i></p>	<ul style="list-style-type: none"> • One containing Third Party name and address • One must be Photographic ID of Third Party
<p>Applying on behalf of a child <i>We will ALWAYS obtain consent for release of records from a child age 13+ to <16 if a third party is making request</i></p>	<ul style="list-style-type: none"> • One which must be Child's birth certificate Photographic ID of person with parental rights

- If you are completing this application on behalf of another person, the Practice will require their authorisation before we can release the data to you.
- The person whose information is being requested should sign the relevant section within the online form.
- If the patient is a child (i.e. under 16 years of age) the application may be made by someone with parental responsibilities – in most cases this means a parent or guardian. If the child is capable of understanding the nature of the application, his or her consent should be obtained or, alternatively, the child may submit an application on their own behalf.
- Children will, generally, be presumed to understand the nature of the application if aged between 13 and 16 however, all cases will be considered individually.

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APPLICATION FOR ACCESS TO MEDICAL RECORDS (SAR)

In accordance with the UK General Data Protection Regulation (UK GDPR)

Section 1: Patient details

Surname		Former name	
Forename		Title	
Date of birth		Address:	
Telephone number		Postcode:	
NHS number (if known)		Hospital number (if known)	

If you are applying to view your own records, please go to **Section 2**.

If you are applying to view another person's record, please go to **Section 3**.

Section 2: Record requested

Please tick the relevant boxes below. 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)

I am applying for an electronic copy of my medical record	<input type="checkbox"/>
I am applying for a printed copy of my medical record	<input type="checkbox"/>

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below)	<input type="checkbox"/>
I would like a copy of records relating to a specific condition/specific incident only (please detail below)	<input type="checkbox"/>
I would like a copy of all my electronic records (held on computer)	<input type="checkbox"/>
I would like a copy of all my electronic and paper records since birth	<input type="checkbox"/>

Patient signature		Date	
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Section 3: Details and Declaration of Applicant

Please complete if you are requesting access on **behalf of** the above-named patient

Surname		Title	
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Forename(s)		Address	
Telephone number		Postcode	
Relationship to Patient			

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

I am applying for an electronic copy of the medical record	<input type="checkbox"/>
I am applying for a printed copy of the medical record	<input type="checkbox"/>

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below)	<input type="checkbox"/>
I would like a copy of records relating to a specific condition/specific incident only (please detail below)	<input type="checkbox"/>
I would like a copy of all the electronic records (held on computer)	<input type="checkbox"/>
I would like a copy of all the electronic and paper records since birth	<input type="checkbox"/>

Reason for access:

I have been asked to act by the patient	<input type="checkbox"/>
I have full parental responsibility for the patient and the patient is under the age of 18 and: <ul style="list-style-type: none"> • Has consented to me making this request, or • Is incapable of understanding the request (delete as appropriate) 	<input type="checkbox"/>
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	<input type="checkbox"/>
I am acting <i>in loco parentis</i> and the patient is incapable of understanding the request	<input type="checkbox"/>
I am the deceased person's personal representative and attach confirmation of my appointment (grant of probate/letters of administration)	<input type="checkbox"/>
I have a claim arising from the person's death (please state details below)	<input type="checkbox"/>

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 UK [Data Protection Act 2018](#).

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.

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Applicant signature		Date	
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I confirm that I give permission for the organisation to communicate with the person identified above regarding my medical records

Patient signature		Date	
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Section 4: Proof of identity

Under the [Data Protection Act 2018](#) you do not have to give a reason for applying for access to your health records.

Patients with capacity and proxy nominees will be asked to provide two forms of identification one of which must be photographic identification. Please speak to reception if you are unable to provide this.

Section 5: Consent for children

If a child aged 13 or over has “sufficient understanding and intelligence to enable him/her to understand fully what is proposed” (known as Gillick Competence), then s/he will be competent to give consent for him/herself.

They may wish a parent to countersign as well.

Young people aged 16 and 17 are legally competent and may therefore sign this consent form for themselves but may wish a parent to countersign as well.

If the child is under 18 and not able to give consent for him/herself, someone with parental responsibility may do so on his/her behalf by signing this form below.

I am the patient aged 13 – 18 years	
Signature	
I am the parent/guardian/person with parental responsibility (delete as necessary)	
Signature	
Full name	
Address	
Date	

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You will be contacted when the copies are ready to arrange suitable delivery (collection, post or email)

ADDITIONAL NOTES:

Before returning this form, please ensure that you:

- Have signed and dated the form
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
- Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

For office use only:

Identification verification must be verified through 2 forms of ID

- One of which must contain a photo e.g., passport, photo driving licence or bank statement.

Where this is not available, vouching by a member of staff or by confirmation of information in the records by one of the clinicians may be used.

If this is a proxy request, where patient has capacity, both patient and proxy should provide identification as above in person.

Request received		Request refused	
Reviewed by		Request completed	
Fee (see section 6.4)		Date sent	
Comments			
Patient identity verified by		Date	
Method	<input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Vouching – by whom <input type="checkbox"/> Vouching with information in record – by whom		
Proxy identity verified by		Date	
Method	<input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Vouching – by whom <input type="checkbox"/> Vouching with information in record – by whom		