QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

FOR OFFICE USE ONLY

To be completed when request has been logged

Staff Initials: _____

Date: _____

Subject Access Request

All patients are entitled to a copy of their personal data. As we process some very sensitive information, certain checks before releasing the information which can take time.

As such it can be helpful to discuss exactly what you require - please call Tina Mauger, Data Access Administrator on 724184.

Patient Details:	
Full Name:	
Date of Birth:	
Address:	
Contact number:	
Details of requestor (if different to above)	
Full name:	
Relationship to patient:	

If requesting data on behalf of a child (under 12 years old), by signing this document you have confirmed you have parental responsibility/guardianship of this child**.**

Following guidance from the GMC, requests for data for children 12 years and over require the patient to complete and sign this form.

Details of records being requested

☐	Complete medical records (includes past medical history, current health conditions, investigations, treatments and correspondence from other organisations)
☐	Specific medical records (please give as much detail as possible including dates, conditions, the more specific you are, the faster we are able to process the request)
☐	Other Data (please give details)
☐	If you have requested your notes as you are moving surgeries or leaving the island please select this box as we have a different process for transferring notes to another GP

QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS

	Please indicate how you would like to receive the records below:
☐	Email to patient: By selecting this box, you are accepting data protection risks regarding electronic communication.
☐	Email to new GP: By selecting this box, you are accepting data protection risks regarding electronic communication.
☐	Download to USB device and posted/collected:
☐	Collect by:
(If someone is collecting these records on behalf of the patient/requestor please complete Section A)	
Signature of patient (or legal guardian if under 12):	
Date:	

Simple Subject Access Requests will be processed within 30 days from receipt of all required documentation. Complex requests can take up to 90 days.

In order to verify patient identity please include a copy of photographic identification with this request. If patient is under 12, a copy of birth certificate and requestor ID is accepted.

Section A: Consent for a 3rd party to collect medical records on behalf of a patient or for medical records to be emailed to a 3rd party			
I give consent for my medical records:			
☐	To be collected by the following 3rd party		
☐	To be emailed to the following 3rd party		
Full name:			
Date of birth:			
Address:			
Signed (by patient):		Date:	
Please attach a copy of photographic ID of the individual collecting the medical records.			

CHECKLIST:

- Fully completed form signed by patient themselves for ages 12+
- Copy of photographic ID of patient
- Copy of photographic ID of person collecting records (if not patient/legal guardian for under 12s)