QUEENS ROAD MEDICAL PRACTICE

Subject Access Request Form

All patients are entitled to a copy of their personal data. As we process some very sensitive information, certain checks before releasing the information are required. It can be helpful to discuss exactly what you require - please call our Data Access Administrator on 881756.

Patient Details:	
Full Name:	
Date of Birth:	
Address:	
Contact number:	

If you are requesting data on behalf of a patient	
Full name:	
Relationship to patient:	
Telephone number or Email address of requester	
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	

☐	**Specific medical records** *(<u>please give as much detail as possible</u> including dates, conditions, this will allow us to process your request more efficiently)*
☐	**Complete medical records** *(<u>please note this will include</u> past medical history, current health conditions, investigations, treatments, correspondence from other organisations and archived paper records)*
☐	**Other records** *(such as accounts information or CCTV images) please give details*
☐	**Requested as you are leaving the island**

QUEENS ROAD MEDICAL PRACTICE

	Please indicate how you would like to receive the records below:		
☐	Email to patient/ requester:		
☐	Email to new GP:		
By selecting the above boxes, you are accepting data protection risks regarding electronic communication.			
☐	Download to USB device and	Posted ☐ or	Collected ☐
☐	Printed and	Posted ☐ or	Collected ☐
If someone is collecting these records on behalf of the patient/requestor please complete the below			
Signature of patient (or legal guardian if under 12):			
Date:			

Subject Access Requests will be processed within one calendar month from receipt of all required documentation. The practice may exercise its right to extend this time frame to three calendar months if requests are deemed as complex, if we exercise this right, you will be informed within the first calendar month.

If you require data prior to the one calendar month deadline, please let us know

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

If someone is collecting these records on your/patients behalf, please complete the below section, if this section is not completed records will be sent directly to the patient.			
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 and/or person collecting records