Appendix A: Form – Subject Access Request Form

Claremont Bank Surgery respects the rights of individuals to have copies of their information wherever possible.
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. It is important that we will need to see the following; photo ID for proof of identification and a proof of residence.
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. Before any further action is taken, we will contact you with details of our "reasonable administrative charges" in order to comply with your request.

PLEASE COMPLETE IN BLOCK CAPITALS – Illegible forms will delay the time taken to respond to requests.	
1.	**Details of Patient/Clients/Staff members records to be accessed** (Please complete one form per person)
Surname	Date of Birth
Forename(s)	Current Address
Any former names (If Applicable)	Full Postcode
Telephone Number	Previous Address (If Applicable)
NHS Number (If known/relevant)	
	Full Postcode
If further details are available please include in a separate covering note.	

2.	**Details of Records to be Accessed**
In order to locate the records you require please provide as much information as possible. Please list the department or services you have accessed that you require records from: i.e. PALs, complaints, continuing healthcare or Human resources etc (Continue on a separate sheet if required).	
Records dated from	**Department or services accessed**
/ / **to** / /	
/ / **to** / /	
/ / **to** / /	

3.	**Details of applicant** (Complete if different to patients/clients/staff members details)
Full Name	
Company (if Applicable)	

Relationship with individual who's records have been requested	
Address to which a reply should be sent	**Postcode:** **Tel:**

4.	**Authorisation to release to applicant** (to be completed by the patients/clients/staff member if not making their own request)

I (Print name)_____ hereby authorise Claremont Bank Surgery to release any personal data they may hold relating to me to the above applicant and to whom I authorise to act on my behalf.

Signature of patient/client/staff member **:** _____ **Date:** / /

5. Declaration

I declare that information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record(s) referred to above, under the terms of the Access to Health Records Act (1990) / Data Protection Act.

Please select one box below:

❑ I am the patient/client/staff member (data subject).

❑ I have been asked to act on behalf of the data subject and they have completed section 4 -authorisation above.

❑ I am acting on behalf of the data subject who is unable to complete the authorisation section above (Covering letter with further details supplied).

❑ I am the parent/guardian of a data subject under 16 years old who has completed the authorisation section above. (Please include proof such as birth certificate)

❑ I am the parent/guardian of a data subject under 16 years old who is unable to understand the request and who has consented to my making the request on their behalf.

❑ I have been appointed the Guardian for the patient/client, who is over age 16 under a Guardianship order (attached).

❑ I am the deceased patient/client's personal representative and attach confirmation of my appointment.

❑ I have a claim arising from the patient/client's death and wish to access information relevant to my claim (Covering letter with further details to be supplied).

Please Note:

- If you are making an application on the behalf of somebody else we require evidence of your authority to do so i.e. personal authority, court order etc.
- It will be necessary to provide evidence of identity (i.e. Driving Licence) and proof of residence.
- If there is any doubt about the applicant's identity or entitlement, information will not be released until further evidence is provided. You will be informed if this is the case.
- Under the terms of the Data Protection Act, requests will be responded to within 30 days after receiving all necessary information and/or fee required to process the request.
- If you are making a request under the Access to Health Records Act 1990, requests will be responded to within 40 days where no entries have been made to the patient/client's record 40 days immediately preceding the date of this request, otherwise requests will be responded to within 21 days after receiving all necessary information and/or fee required to process the request.
- Under the terms of Section 7 of the Data Protection Act, Information disclosed under a Subject Access Request may have information removed; this is to ensure that the confidentiality is maintained for third parties referred to who have not consented to their information being disclosed.

Print Name		**Signed (Applicant)**		**Date**	/ /

Please complete and send this document to:

Claremont Bank Surgery, Claremont Bank, Shrewsbury SY1 1RL.

Records not collected by 8 weeks will be destroyed.

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Office Use Only;

Request Received; **Date;**

ID Seen and Checked by; **Date;**

Request Completed; **Date;**

Patient/Client/Staff member informed health records are ready for collection;

Date;

Patient/Client/Staff member collected records; **Date;**