**Subject Access Request (SARs)**

|  |  |
| --- | --- |
| **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.** | **DPA_Padlock__blue_** |
| **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.  |
| **By completing this form, you are making a request under the General Data Protection Regulation (GDPR) for information held about you by the practice that you are eligible to receive** **\*Please hand this form into Reception. Allow up to 30 days for a reply** |
| Name: |  Date of Birth: |
| Daytime telephone number: Mobile telephone number: |
| Email: |
| Have you registered for on-line access to your medical records: Yes or No (please delete as appropriate) |
| Address: |
| **1.** | Required information (and any relevant dates): |
|  |  |
| **2.** | Reason for request: |
|  |  |
| Print Name | Signature | Date |

**Please bring photographic identification with you when you collect your data**

**If someone else is requesting information on your behalf please continue over the page**

**If you are requesting information on behalf of someone else**

|  |  |
| --- | --- |
| **3.** | **Details of applicant** (Complete if not the patient) |
| Full Name |  |
| Relationship to Patient |  |
| Full address |  |
| Signature |  |
| **4.** | **Authorisation to release to applicant** (to be completed by the patientif not making their own request) |
| I (Print name) hereby authorise Colchester Medical Practice to release information as per section 1 to the above applicant and to whom I authorise to act on my behalf.Signature of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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 record(s) referred to above, under the terms of the Access to Health Records Act (1990) / Data Protection Act.

**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 may be necessary to provide evidence of identity (i.e. Driving Licence).
* 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 21 days after receiving all necessary information and/or fee required to process the request.
* For requests 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.

**For Office use only**

Request received by:

|  |  |  |
| --- | --- | --- |
| Print Name | Signature | Date |

Request authorised by:

|  |  |  |
| --- | --- | --- |
| Print Name | Signature | Date |