Annex B – Application for access to medical records (SAR)

APPLICATION FOR ACCESS TO MEDICAL RECORDS (SAR)

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

Section 1: Patient details

Surname		**First Name**	
Date of birth		**Address & postcode**	
Telephone number			

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	☐
I am applying for a printed copy of my medical record	☐

Please specify what information you are requesting:- Specify dates

Patient signature		**Date**	

Section 3: Details and Declaration of Applicant

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

Surname		**First name**	
Address and Postcode		**Telephone number**	
Relationship to Patient			

Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and the patient is under the age of 18 and: • Has consented to my making this request, or • Is incapable of understanding the request (delete as appropriate)	☐
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	☐
I am acting *in loco parentis* and the patient is incapable of understanding the request	☐
I am the deceased person's personal representative and attach confirmation of my appointment (grant of probate/letters of administration)	☐
I have written, and witnessed, consent from the deceased person's personal representative and attach Proof of Appointment	☐
I have a claim arising from the person's death (please state details below)	☐

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.
Please note- If you demand is excessive we will charge you the admin cost that means.

- requesting the same medical records within 6 month,
- Number of printout is more 30 pages.

Note- We can send your request to IGPR(a third party) who will process your request in 28 days in accordance with our instructions and all applicable laws, including UK data protection laws. This will be chargable .If you do not wish to process your request through IGPR then please inform the receptionist. For further information please visit our website.

Applicant signature		**Date**	

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

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.

Section 4: 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		Date	
I am the parent/guardian/person with parental responsibility (delete as necessary)			
Signature		Full name & date	

You will be telephoned when the copies are ready for collection or posting.

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.

Date Request received		Fee informed	Yes or NO (please circle)
Patient identity verified by (including proxy request)			
Method	☐ Photo ID or proof of residence – Type ..... ☐ Photo ID or proof of residence – Type ..... ☐ Vouching – by whom ..... ☐ Vouching with information in record – by whom		