**Subject Access Request Form (Request for personal data)**

Subject Access Request is the request for information, which is about the data subject who is a living individual. The Access to Health Records Act 1990 (AHRA), the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA) give individuals (“Data Subjects”) rights to accessing information held about them by organisations (“Data Controllers”).

GDPR/DPA relates specifically to information relating to living individuals.

The AHRA deals with the living and deals with the disclosure of deceased persons’ health records. Under the AHRA, when a person dies their personal representative, executor, administrator may gain access. Where the record indicates that the deceased person did not wish for their information to be disclosed, then this must remain so unless a court order is obtained. Access to a deceased patient’s health record is provided on the basis of the request under AHRA, as the Common Law Duty of Confidentiality remains after a person is deceased.

**Provide copies of your Health record to you**

**Electronically:** We will provide copies of your health records electronically to cut down on time, cost and environmental damage. This will be provided via a secure email.

**Collection:** If collecting paper copies of your records please bring proof of your identity e.g. passport, driving licence etc.

If someone is collecting your records for you, then let us know beforehand. They must bring proof of their identity and written authorisation signed by you to allow them to collect the documentation.

**How long will it take to get my records?**

We will try to respond to your request within the statutory timeframe of one calendar month.As stated above, this is subject to receiving valid proof of identity to ensure that you have a legitimate right to access the data.

If your request is complicated, we will inform you and may extend the deadline up to a maximum of 2 further calendar months.

**Exemptions**

There are several exemptions that are set out under the GDPR and Data Protection Act 2018 which allow information to be withheld from disclosure. Some of the current exemptions include the following:

* A disclosure of third-party personal data, unless the third-party consents to their data being disclosed in response to the request, or there are overriding Public Interest considerations in disclosing that data. Wherever possible, we will seek the consent of the third party to disclose their personal data in response to a request, without disclosing personal data about you, the requestor.
* A disclosure of information which is likely to cause serious physical or mental harm to you or another person.
* A disclosure of information which relates to legal advice or legal proceedings, as this is covered by legal professional privilege.

**How to Submit your application**

1. Email: Please send the form and evidence to [warrenlane.medicalcentre@nhs.net](mailto:warrenlane.medicalcentre@nhs.net)
2. Post: Please send the request and evidence to

**Warren Lane Surgery**

**Warren Lane**

**Leicester Forest East**

**Leicester LE3 3LW**

1. Hand Delivery: Please drop your request and evidence off at Warren Lane reception.

**Sections of this form: Explanations and what needs to be completed.**

**Section 1: Details of the Data Subject (Patient) – Compulsory, all applications**

**Section 2: Details of the Person (The Representative) acting on behalf of the data subject – To be filled in when a representative is applying for access, or the records are for a deceased patient.**

**Section 3: Description of the information requested – Compulsory, all applications.**

* **Part A** data range
* **Part B** additional information
* **Part C** Reason for request – **Compulsory, Deceased patients only**

**Section 4: Declaration – for access to LIVING patients’ records**

* **Part A** should be completed by the data subject/patient.
* **Part B** should be completed by a Representative who has been given authority by the data subject or the courts, **adults** only.
* **Part C** For a **child’s** data: should be completed by a responsible adult / legal parent / guardian.

**Section 5: Supporting documents and identification –** All applications.

**Section 6: Declaration –** for access to **DECEASED** patient Records only

**SUBJECT ACCESS REQUEST FORM**

Please complete the application form in **BLOCK LETTERS**.

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| Section 1: Details of the Data Subject (Patient) | | | | | |
| *This section must be completed for all applicants.*  *Please complete all details relating to the data subject (person about whom the information is requested)* | | | | | |
| Surname: |  | | | Title |  |
| Forename(s) |  | | | | |
| Date of birth: |  | | | | |
| NHS or Hospital number |  | | | | |
| Current address |  | | | | |
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| Country |  | Post Code | | |
| Previous address |  | | | | |
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| Country |  | Post Code | | |
| Telephone/mobile n° |  | | | | |
| Email address |  | | | | |

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| Section 2: Details of the Person (The Representative) acting on behalf of the Data Subject | | | | | | | | | |
| *This section should only be completed when the application is being submitted on behalf of the data subject on the authority of the data subject or the courts.*  *The section must also be completed if the request is for access to a deceased patient’s health records* | | | | | | | | | |
| Surname | |  | | | | | Title | |  |
| Forename(s) | |  | | | | | | | |
| Current address | |  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| Country | |  | | Post Code | | | |
| Telephone/mobile n° | |  | | | | | | | |
| Email address | |  | | | | | | | |
| Section 3:Part A - Description of the information requested. | | | | | | | | | |
| Dates required: | From DD/MM/YY) | |  | | To (DD/MM/YY) | | |  | |
| Dates required: | From DD/MM/YY) | |  | | To (DD/MM/YY) | | |  | |
| Dates required: | From DD/MM/YY) | |  | | To (DD/MM/YY) | | |  | |
| Dates required: | From DD/MM/YY) | |  | | To (DD/MM/YY) | | |  | |
| Part B - Additional Information: | | | | | | | | | |
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| Part C - Reason for request – **Deceased patients only** | | | | | | | | | |
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| **Please tick the appropriate box to indicate how you would like to receive the copies of the records** | | | |
| **For either the PATIENT (data subject)** | | **Or the REPRESENTATIVE** | |
| **Electronic copies of my email are given in Section 1** |  | **Electronic copies to my email in Section 2 acting on behalf of:** |  |
| **Or paper copies-collection in person** |  | **Or paper copies-collection in person on behalf of:** |  |

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| Section 4: Declaration - please complete either Part A or B or C (Living patient records only) |
| **Part A: I am the data subject (Patient)**  I, the undersigned declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply under the Access to Health Records Act 1990, the GDPR and the Data Protection Act 2018 for access to personal data that the GP holds about me under the terms of that Act. I understand that it is necessary for the GP to confirm my identity and it may be necessary to obtain more detailed information to confirm my identity and/or locate the correct information.  Full name (Data subject/Patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Part B: I am the representative acting on behalf of the data subject (patient – adult only)**  **Please tick the relevant box below (ONE box only)**  I have been authorised by the Data Subject named at **Part A** (who has capacity) to act on their behalf and attach their written authorisation.  **or**  I am acting on the behalf of the data subject, who lacks capacity, and I hold Lasting Power of Attorney for Health and Welfare, or I have been appointed as the Independent Mental Capacity Advocate and attach proof of appointment. Please tick the appropriate box below.  Proof of Lasting Power of Attorney for Health and Welfare  Proof of appointment as the Independent Mental Capacity Advocate  **Representative’s Declaration**  I am aware that it is an offence to unlawfully obtain such information—for example, by impersonating the patient. I certify that the information given in this form is true.  Full name of representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Part C: I am the authorised representative of the CHILD named in Section 1**  **Please tick the relevant box below (ONE box only)**  I am acting on the behalf of a child **under** 14 years old and I have parental responsibility for them.  I am acting on the behalf of a child aged 14 or over and I have parental responsibility for them. I can confirm they are not capable of understanding the request (not Gillick competent).  I am acting on the behalf of a child aged 14 or over and I have parental responsibility for them. I can confirm they are capable of understanding the request (Gillick competent).  I have attached proof of parental responsibility: birth certificate, marriage or civil partnership certificate, court order or parental responsibility agreement.  Full name of requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Section 5: Supporting documents and identification |
| For us to release records we need to have proof of ID and assure ourselves of the legitimacy of the request. We are not obliged to comply with a request unless we are supplied with such information as we may reasonably require to satisfy ourselves of the identity of the requestor  To confirm proof of identity**\***, you will need to send us:   * One of the documents from the proof of identity list below * One item from the proof of the address list below |
| **\*** If you are making a request on behalf of another person, then you will need to provide proof of identity & address **for both you and the Data Subject.**  If we require further information or documentation to support a request, then we will contact you and your request will be put on hold.  **Please tick the appropriate boxes to indicate which documents you have enclosed:** |

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| **Proof of identity** | **Proof of address** | **Proof of Parental Responsibility** |
| Current passport  Current photo card driving licence.  Current EU driving licence  HM Forces ID card | Utility bill (no more than 3 months old)  Council tax bill for current year  Current benefit book or card, or original notification from the Department of Work and Pensions confirming rights to benefits.  Recent bank statement (no more than 3 months old) | Birth certificate    Marriage certificate  Civil partnership certificate  Court order  Parental responsibility agreement |

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| Section 6: Declaration: for requests for deceased patients records only |
| I declare that the information given by me is correct to the best of my knowledge and I am entitled to apply under the Access to Health Records Act 1990 because:  I am the Executor of the will and attach a copy of the last will executed by the deceased person, certified by a solicitor, showing the applicant named as executor.  I hold a Representative of the patient’s estate and attach a Grant of Letters of Administration / a sealed Grant of Probatecertified by a solicitor in respect of the deceased’s estate.  I have a claim arising from the death by the court to manage the patient’s affairs and I attach a certified copy of the court appointing me to do so.  I have a claim arising from the patient’s death and wish to access information relevant to my claim and attach documentary evidence to support this (solicitor’s letter)  Full name of representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |