**Ratby Surgery Subject Access Request (SAR)**

You will appreciate that health data relating to any individual is highly confidential and the Practice must ensure that it releases such data only to the person to whom it relates, or to a person authorised to act on his or her behalf. If you require to see any health data, please complete this online Request Form as fully and accurately as possible to enable us to locate the exact information you require.

The General Data Protection Regulations (GDPR) gives you the statutory right of access to any information, manual (paper) or computerised. You may wish to authorise someone else to make your application on your behalf and if you have parental responsibilities you may make an application to see your child’s notes.

You do not have to give a reason for applying for access to your General Practice records. If you do not need access to your entire records, it would be helpful if you would inform us of the periods and area of your health records that you require, along with details which you feel may have relevance (e.g. clinic type, location, dates).

**Timescale**

The Practice will deal with your request as quickly as possible. The information should be available to you within 28 days of receipt of your accurately completed form and confirmation of consent. Under certain circumstances, this period can be extended to 3 months but we will keep you informed of the progress of your request during this extended period.

**Fees**

We will not make a charge for the first request for access to your medical records. We may, however, charge for subsequent requests or if we deem that the volume of information requested is excessive. You have the right to simply view your records (i.e. not receive a copy in a permanent form); information on how to arrange this is detailed below.

**Type of request**

If you request to see the original records, you will be invited to make an appointment at a mutually convenient time to view them. If you request copies, these will be ready within the allocated timescales specified by the Regulations, and we will telephone you when they are available for you to come to the Practice to collect them.

**Proof of identity**

Two forms of identity must be provided (one of which must be photographic). This is to ensure information is not released to unauthorised individuals. The table below outlines the proof of identity we can accept.

|  |  |
| --- | --- |
| **TYPE OF APPLICATION**  | **IDENTIFICATION REQUIRED**  |
| **Patient applying for their own**Can be waived if the applicant is known tothe Staff Member accepting the request   | One which must be photographic i.e. Passport, one containingindividuals name & address |
| **Third Party Applying.** Consent of Patient will be required**BEFORE** the request will be processed   | One containing Third Party name address ,one must be Photo ID of the Third Party |
| **Applying on behalf of a child**We will **ALWAYS** obtain consent for releaseof records from a child age 13+ to <16 if athird party is making request. | One which must be child’s birth certificate Photo ID of person with parental rights |

If you are completing this application on behalf of another person, the Practice will require their authorisation before we can release the data to you. The person whose information is being requested should sign the relevant section within the online form. If the patient is a child (i.e. under 16 years of age) the application may be made by someone with parental responsibilities –in most cases this means a parent or guardian. If the child is capable of understanding the nature of the application, his or her consent should be obtained or, alternatively, the child may submit an

application on their own behalf. Children will, generally, be presumed to understand the nature of the application if aged between 13 and 16 however, all cases will be considered individually.

**Privacy Policy**

This form collects your name, date of birth, email, other personal information and medical details. This is to confirm you are registered with the practice, to allow the practice team to contact you and also to update your medical records held by the practice and our partners in NHS.

**Applicant Details**

First Name Last Name

|  |
| --- |
|  |

|  |
| --- |
|  |

**I am requesting**

My own medical records

The medical records of another adult

The medical records of a child

Email

Enter Email

Please confirm your email

Confirm Email

Date of birth Preferred Phone No.

|  |
| --- |
|  |

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| --- |
|  |

Please use format day/month/year e.g.

**Type of Request**

I wish to request

View Records

 Copy of Parts of Medical Records From\_\_\_\_\_\_\_\_\_\_\_To\_\_\_\_\_\_\_\_\_\_

Partial Medical Records From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_To\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Medical Records

Other(please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent**

Tick which applies

I am the Patient

I have been asked to act by the patient as detailed and who has signed the authorisation section.

I am the parent/guardian of a patient who is between the age of 12

years old and 16 years old who has signed the authorisation section.

I am the parent/guardian of a patient who is under 12 year old is unable to understand the request.

Signature of Applicant

**May 2021**

**shared**

**GDPR protocols**