**RIVERSIDE SURGERY**

General Data Protection Regulation (GDPR) - Subject Access Request

**Details of Record to be accessed:**

|  |  |
| --- | --- |
| Patient Surname: | NHS Number: |
| Forename(s) | Address |
| Date of Birth: |  |

**Details of Person who wishes to access the records, if different from above:**

|  |  |
| --- | --- |
| Surname | Address: |
| Forename |  |
| Telephone Number | Relationship to Patient |

**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 General Data Protection Regulation (GDPR). I understand that, under the terms of the Regulation, the practice has 30 calendar days in which to respond to this request.

**Tick** which every of the following statements apply:

* I am the patient
* I have been asked to act by the patient and attach the patients written authorisation
* I am acting in Loco Parentis and the patient is under age sixteen, and is incapable of understanding the request / has consented to me making this request. (\*delete as appropriate).
* I am the deceased patient’s Personal Representative and attach confirmation of my appointment.

Your Signature……………………………………………. Date…………………………………

**Note:** **If the request is manifestly unfounded or excessive charges will apply**

Details of my Application (please **tick** as appropriate) **Patient to complete:**

|  |  |
| --- | --- |
| **I am applying for access to my records online which is free of charge** |  |
| I am applying for access to view my records only |  |
| I am applying for copies of my medical record |  |
| **I will supply photographic ID when I attend the practice** |  |
| I agree to pay the appropriate fee if the request is manifestly unfounded or excessive – we will inform you if this fee is applicable. |  |

*Under General Data Protection Regulation (GDPR) you do not have to give a reason for applying for access to your health records.*

**Optional** – Please use this space below to inform us of certain periods and parts of your health record you may require, or provide more information as requested above.

This may include specific dates, consultant name and location, and parts of the records you require e.g. written diagnosis and reports. Note: defining the specific records you need may result in lower fee charges and a quicker response.

|  |  |
| --- | --- |
| I would like a copy of all records |  |
| I would like a copy of records between specific dates only (please give date range) below |  |
| I would like copy records relating to a specific condition/specific incident only (please detail below) |  |