OLD MILL SURGERY
NEWTOWNARDS

***Patient Authority Consent Form***
***Subject Access Request (SAR)***

**Access to Health Records under GDPR (General Data Protection Regulation)**

The GDPR (General Data Protection Regulation) gives every living person, patients (data subjects) the right to have access to their data and any supplementary information held by Old Mill Surgery. This is known as a subject access request (SAR).

**Access**

- You must submit a Subject Access Request (SAR) form. Copies of this form are available from our reception or can be downloaded from our website
- Completed forms to be submitted to the Practice for the attention of the Practice Manager
- Patients do not have to pay a fee for copies of their records.
- Once the SAR form has been received we will aim to process the request within 1 calendar month, however, this may not always be possible.

**Exemptions**

In some circumstances, the Act permits the data controller to withhold information held in your health record. These rare cases are:

- ✓ Where it has been judged that supplying you with the information is likely to cause serious harm to the physical or mental health or condition of you, or any other person, or:

- ✓ Where providing you with access would disclose information relating to or provided by a third person who had not consented to the disclosure, this exemption does not apply where that third person is a health professional involved in your care.

When making your request for access, we would ask you to provide details of the periods and parts of your health record you require. Although this is optional, it will help save time and resources.

If you are using an authorised representative, you need to be aware that in doing so they may gain access to all health records concerning you, which may not be relevant. If this is a concern, you should inform your representative of what information you wish them to specifically request when they are applying for access.

If you have any complaints about any aspect of your application to obtain access to your health records, you should first discuss this with the health professional concerned. If this proves unsuccessful, you can make a complaint through the Complaints Procedure by contacting our Practice Manager on 028 91240600 or request a complaints form from our reception.

**Application Form for Access to Health Records** (in accordance with the General Data Protection Regulation (GDPR)

**Subject Access Request**

This form must be completed in full and signed to allow us to process your request

**Section 1:**

**Patient Details:** Identity of individual about whom information is requested

| | |
|---|---|
| Full Name | Former name (s) |
| Current address | Former address (with date of change) |
| Date of birth | H&C Number (if known) |
| Contact phone number (Day time if possible) | E-mail address (optional) |

**Section 2:**

**Dates and types of records requested**

To help the save time and resources, it would be helpful if you could provide details below informing us of periods and parts of your health records you require, along with details which you may feel have relevance i.e. consultant name, location, written diagnosis and reports etc. Please complete the boxes below.

**Please provide me with: (**indicate below**)**

| | |
|---|---|
| A copy of all records held | |
| A copy of records between the dates specified below: | |
| A copy of records relating to the incident specified below: | |
| A copy of records relating to the condition specified below: | |

**Section 3: Details and declaration:**

Please enter details of applicant if different from Section 1.

| | | | |
|---|---|---|---|
| **Surname** | | **Forename (s)** | |
| **Address (Including postcode)** | | | |
| **Tel No:** | | **Date of birth:** | |

**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 GDPR.

☐ I am the patient

☐ I am applying on behalf of the patient and I attach the patient's written consent

☐ I have full parental responsibility for the patient and the patient is under 18years of age and
- Has consented to me making this request or
- Is incapable of understanding the request (delete as appropriate)

☐ I have a claim arising from the person's death

☐ I have been appointed to manage the patient's affairs by the court and attach a copy of the court order

☐ I am the deceased person's next of kin

Signature of applicant: …….. Date: ……

## 4. Evidence

**Evidence of identity will be required for either the patient and/or patient's representative. Please attach copies of this evidence. Examples of documentation accepted are detailed below**

| Applicant | Documentation required | Documentation Received |
|---|---|---|
| A patient applying for his/her own medical records | One copy of any of the following is required<br>➢ Copy of birth certificate<br>➢ Copy of passport<br>➢ Copy of driving licence<br>➢ Copy of bus/travel pass<br>➢ | |
| A person applying on behalf of an individual (Representative) | One copy showing proof of patient's identity and one copy showing proof of the representative's identity (from list below)<br>➢ Copy of birth certificate<br>➢ Copy of passport<br>➢ Copy of driving licence<br>➢ Copy of bus/travel pass | |
| Person with parental responsibility applying on behalf of child | Copy of child's birth certificate & copy of correspondence address to person with parental responsibility relating to the patient | |
| Appointment to manage patient's affairs | Copy of court order relating to patient | |

5. Countersignature:
This section can be completed by someone (other than a family member) who can vouch for your identity. The section may be completed if evidence in number 4 cannot be fulfilled.

I ……. (Insert full name)

Certify that the applicant (insert name) ……..

Has been known to me personally as …….. For ……years
Capacity known: e.g. employee, client, patient, relative, etc.

And that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed …….. Dated ……

Name (please print) …… Profession ……

Address ……

…….

Daytime telephone number ……

**NOTES:**

Before returning this form, please make sure you have:

a. Signed and dated this form

b. Enclosed proof of your identity or alternatively confirmed your identity by a countersignature

c. Enclosed documentation to support your request

**INCOMPLETE APPLICATIONS WILL BE RETURNED**

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**(Office use only)**

Date application received: ……..

Received by: ……