**STUBBINGTON MEDICAL PRACTICE – SUBJECT ACCESS REQUEST**

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| **I would like to make a Subject Access Request for my personal information.** |
| **Name of patient** |  |
| **Date of birth** |  | **NHS number** **(if known)** |  |
| **Date of request** |  |
| **You only need to complete this form if you want a copy of your medical record.****If you would like secure online access to your electronic record, please complete the enclosed Online Access application form and return it to the surgery.** |
| **Request details – please state exactly what information you want.***If all records are required, please state ALL in each field.** Information required between dates ………………………… and …………………………
* Relating to the medical condition(s) / incident(s):

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**Yes / No***Please note that all significant information from your paper record is included in your electronic record, and that a copy of the paper record may take longer to process.** Do you also require copies of correspondence/hospital letters we may hold?

 **Yes / No** *This will not include all hospital letters and records – we recommend you make a request directly to the hospital if these are required.*Please note:We do not routinely release Child Protection or similar reports/information of a highly sensitive nature. Your records will be redacted to protect any named third parties, and will be checked by a GP before they are released to you. |
| We can provide the information to you in the following formats, **please specify your preference:*** Paper copy, to be collected from Reception
* Encrypted email

Please note: We do not charge a fee for a first request for medical records, but should you ask us again for the same records it would be considered an excessive request and we would have to charge for a second and any subsequent copies.Once you have accepted this copy of your notes, any further transmission and use of the information within your notes is your own responsibility, and that the practice cannot be held liable for any misuse of your information by any third parties you release it to. |
| *I confirm my request for access to my medical records as per the above details.* *I confirm that by accepting these notes I am responsible for any further transmission and use of the information.* *I understand that I will be charged for any subsequent requests.*Patient signature: ……………………………………………………………..… Date: …………………………………… |
| For office use only:Photo ID checked by: ……………………………………………………….... Date: …………………………………… |