

## Request to Access Personal Records

### ***PRIVATE AND CONFIDENTIAL***

**SAR1** Subject Access Request

General Data Protection Regulation (EU) 2016/679 and Data Protection Act

The form should be filled out in block capitals or in type.

#### **Section 1: Details of person whose records are being requested**

Surname:	
Former Surname:	
First names:	
Title:	Mr/Mrs/Ms/Miss/Other
Date of Birth:	
NHS Number:	
Current Address:	
Former Address : (if applicable)	

#### **Section 2: Applicant details (if making a request on behalf of the person above)**

Name:	
Address:	
Relationship to person in section 1:	

#### **Section 3a: Records to be released**

I understand that filling in and signing this form gives you permission to release copies of the following GP records to the person whose details are given above:

Please tick **one**:

Full electronic record

Full electronic record + old paper notes (please bear in mind that this option will take a few weeks longer as we need to request your notes from our off-site unit and then copy them)

**Section 3b:**

Please tick **one**:

Full copy of my records

Records for the period from ..... to .....

**Section 4: Consent**

Please tick **one** of following boxes and sign below:

I confirm I am the person mentioned in section 1 and I require access to my personal records. I will collect these from Saltash Health Centre	<input type="checkbox"/>
I confirm I am the person mentioned in section 1 and I authorise the release of copies of my personal records (described in section 3) to the person mentioned in section 2.	<input type="checkbox"/>
I confirm that I am the person mentioned in section 2 and I have parental responsibility for the child in section 1. I will collect these from Saltash Health Centre.	<input type="checkbox"/>
I confirm I am the person mentioned in section 2 and have been authorised to act as an agent/power of attorney for the patient in section 1. I will collect these from Saltash Health Centre.	<input type="checkbox"/>

Name:	PLEASE WRITE NAME IN CAPITALS
Signature:	
Date:	

Please return the form to:  
The Medical Records Officer  
Saltash Health Centre  
Callington Road  
Saltash  
Cornwall  
PL12 6DL