

# COLLEGE STREET MEDICAL PRACTICE

86 College Street, Long Eaton, Nottingham, NG10 4NP | Tel: 0115 973 4502

## Subject Access Request

*Request a copy of your GP medical records and personal information*

**Before you start:** Please complete the sections below. Tick the boxes that apply to you. If you need help completing this form, contact the GP practice.

Date submitted

\_\_\_ / \_\_\_ / \_\_\_\_

### 1 YOUR DETAILS

|                         |  |
|-------------------------|--|
| Full name               |  |
| Date of birth           |  |
| NHS number              |  |
| Home address & Postcode |  |
| Telephone               |  |
| Email                   |  |

### 2 WHAT YOU ARE ASKING FOR

I am making a Subject Access Request (SAR) and would like a copy of the personal information and medical records the GP practice holds about me. I understand that I do not need to give a reason for my request.

**Choose one option:** Tick "My complete GP medical record" if you want everything or select the individual items you need.

☐ **My complete GP medical record**

**OR select the records you need:**

- |                                                                                     |                                                               |
|-------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> GP consultations and clinical notes                        | <input type="checkbox"/> Diagnoses and medical history        |
| <input type="checkbox"/> Medicines and prescription information                     | <input type="checkbox"/> Test results and investigations      |
| <input type="checkbox"/> Referral letters and referral information                  | <input type="checkbox"/> Hospital correspondence              |
| <input type="checkbox"/> Letters and reports from other healthcare professionals    | <input type="checkbox"/> Immunisation and vaccination records |
| <input type="checkbox"/> Information about my treatment and care                    |                                                               |
| <input type="checkbox"/> Communications about me containing my personal information |                                                               |
| <input type="checkbox"/> Other personal information held by the practice            |                                                               |

**If you selected "Other", please describe what you need:**

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### 3 DATE RANGE

Tell us which period your request covers. Tick one option:

- ☐ **My complete medical record**
- ☐ **Records from:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **to** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### 4 HOW YOU WOULD LIKE TO RECEIVE YOUR RECORDS

Choose your preferred format:

- ☐ Secure electronic copy ☐ Paper copy
- ☐ Other: \_\_\_\_\_

#### Keeping your information secure

The practice may contact you to confirm your identity and agree a secure way to provide your records.

### 5 IF INFORMATION CANNOT BE PROVIDED

When patients, their representatives or other third parties ask for copies of medical records; the Practice may redact any information from patients' medical notes that relates to any third-party information, and/or any information which could cause serious harm to the patient or others if it were to be disclosed. The extent of redaction will depend on who has asked for the records, who the third party is and the origin of where that information came from.

### 6 CONFIRMATION AND SIGNATURE

Please confirm that you have received this request. I understand that a Subject Access Request should normally be answered within one calendar month of receipt, subject to the applicable rules on identity checks, clarification and complex requests.

**I/We confirm that this request is not for the purpose of intended action against the Practice, a doctor, member of staff, hospital or the Health Authority**

Please send the response and records securely using my contact details in section 1.

|           |  |
|-----------|--|
| Signature |  |
| Full name |  |
| Date      |  |

#### FOR PRACTICE USE ONLY

|                        |                                                          |                         |                                                          |
|------------------------|----------------------------------------------------------|-------------------------|----------------------------------------------------------|
| Date received          |                                                          | Identity check required | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Identity confirmed     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date confirmed          |                                                          |
| Clarification required | <input type="checkbox"/> Yes <input type="checkbox"/> No | Due date                |                                                          |