**Cranleigh Gardens Medical Centre**

Cranleigh Gardens

Bridgwater

Somerset

 TA6 5JS

 Tel: 01278 433335

[www.cranleighgardensmc.co.uk](http://www.cranleighgardensmc.co.uk/)

SUBJECT ACCESS REQUEST

ACCESS TO HEALTH RECORDS (DATA PROTECTION ACT 1998)

Surname: Forename:

Date of Birth: NHS No:

Address:

**Declaration by patient or patient’s representative requesting access to medical records:**

I wish to view or obtain copies of my electronic and paper records under the terms of the Data Protection Act (1998) and according to my requirements as follows:

Important: Please delete the section which does not apply. If you do not specify, all of your records will be copied and you will be charged accordingly.

1. Please supply a copy of the whole content of my records

2. Please supply a copy of my records from date …………………………………….

3. I wish to look at my records but do not require a copy

***Disclaimer***

* I understand that my family doctor has no control over what happens to copies of records once they leave these premises
* I understand that it is my responsibility to arrange for the storage or destruction of the copies of records once I have taken receipt of the copies
* I understand that only records that would directly damage my health if disclosed or those which contain confidential information about another person will be withheld by the doctor unless I have specified to the contrary
* I understand that an access fee of £10 will be due plus an administrative fee based on the volume of photocopying. The fee is payable before records are viewed or copied. Copies will be ready for collection within one week of payment being made (cheques payable to Cranleigh Gardens Medical Centre)

In this case the fee due is: £ …………………………

**I certify** that I am the patient/patient’s personal representative (because the patient is under sixteen AND/OR is incapable of understanding the request OR has consented in writing to my making the request – please attach written consent or evidence of appointment of lasting power of attorney), OR is deceased and I am making application under the Access to Health Records Act 1990 and have been appointed to act by the patient’s executor.

Please provide two forms of identification, including photo ID such as passport or driving license and proof of address plus any consent required as stated above when collecting copies or attending to view medical records.

Signed: ………………………………………………. Date: …………………………………..

Name in full (if not the patient): (block capitals) ………………………………………………………………….

**Official Use:** Fee (£ ) received [] Records copied [] GP ( Dr ) review [] Records viewed (date )

Revised 03/11, Reviewed Oct 14 and May 2018