ABOYNE MEDICAL PRACTICE

DATA SUBJECT ACCESS REQUEST

Section 1 – Details of the records to be accessed	
Mr/Mrs/Miss/Ms	Date of Birth
Surname	Current Address
Forename	Postcode
Telephone Number	Email Address
By completing this form you are making a request under the General Data Protection Regulation (GDPR) for information held about you by the Practice that you are eligible to receive.	

Section 2 - Details of Records to be Accessed	
☐ Health records dated from/to:	☐ Health records relating to the following injury or condition: .....
☐ Immunisations	☐ All information contained in my records from birth
☐ All health records except those relating to the following condition	☐ Other ....
How would you like to be informed when the records are ready to collect? Telephone: ☐ Email ☐	

Section 3 – Declaration

By signing below you indicate that you are the individual named above. The Practice cannot accept requests regarding your personal data from anyone else, including family members. We may need to contact you for further identifying information before responding to your request.

Signed…….....…… Date……..

Disclaimer – Please be aware your medical record may contain sensitive information which you may or may not be aware of and the Practice cannot accept any liability for any distress that such information may cause.

Please hand this form to the Receptionist. You will be required to bring photo ID and sign a form to acknowledge receipt and responsibility for your record when you collect.

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NOTE:
Information must be provided within 30 days of receipt of the completed application, 21 days to access records of the deceased)

GP USE ONLY

Name of lead health professional.....

I am happy for access to be granted ☐ I am not happy for access to be granted ☐

Signed ..... Date .....

ADMIN USE ONLY

Action	Signed	Date
Date extracted		
Date checked		
Notes checked for third party information		
Patient advised ready to collect		
Supervision appointment required Y ☐ N ☐		

Appointment made with *on* *at*

Further comments:

PRACTICE USE

Photo ID seen and verified ☐

Date _____

Signed _____

PATIENT

I acknowledge receipt and responsibility of requested records

Signed _____