GENERAL DATA PROTECTION REGULATIONS
SUBJECT ACCESS REQUEST - FORM

You will appreciate that health data relating to any individual is highly confidential and Turriff Medical Practice must ensure that it releases such data only to the person to whom it relates, or to a person authorised to act on his/her behalf. Please complete the Request Form as fully and accurately as possible to enable us to locate the exact data you require.

The General Data Protection Regulations gives you the statutory right of access to any information. You may wish to authorise someone else to make your application on your behalf. If you have parental responsibilities you may make an application to see your child's notes.

You do not have to give a reason for applying for access to your general practice records. However it would be helpful if you would inform us, if you do not need access to your entire records, of the periods and parts of your health records that you require, along with details which you may feel have relevance (e.g. Clinic type, location, dates)

Timescale
Turriff Medical Practice will deal with your request as quickly as possible, however the information should be available to you within 28 days of receipt of your accurately completed form and confirmation of consent. However this period can be extended to 3 months but we will keep you informed of the progress of your requests during this extended period.

Fees
We will not make a charge for the first request for access to your medical records however we may charge for subsequent requests and if we deem that the volume of information requested is excessive. You have the right to simply view your records (i.e. not receive a copy in a permanent form).

Type of Request
If you request to see the original records you will be invited to make an appointment at a mutually convenient time to view them. If you request copies these will be ready within the allocated timescales specified by the Regulations and you will be telephoned to come to the Practice to collect them. We will retain for two months and destroy thereafter if not collected within that timeframe. Once we provide you with the records you have requested we will not provide this information again, it is your responsibility to keep a copy if you are sending to a third party.

Proof of identity
Two forms of identity must be provided (one of which must be photographic) this is to ensure no information is released to unauthorised individuals. The table below outlines the proof of identity required.

TYPE OF APPLICATION	**IDENTIFICATION REQUIRED**
Patient applying for their own *Can be waived if the applicant is known to the Staff Member accepting the request*	• One which must be photographic i.e. passport
Third Party Applying *Consent of Patient will be required **BEFORE** the request will be processed*	• One must be Photographic ID of Third Party
Applying on behalf of a child *In Scotland the age of consent is 12. We will **ALWAYS** obtain consent for release of records from a child age 12+ to <16 if a third party is making request*	To establish Parental Responsibility: • Child's birth certificate also • If not named on birth certificate copy of marriage certificate.

Identification Verified by Receptionist:	Signature:	Date:

☐ **ID Provided** ☐ **Patient Known to Receptionist**

If you are completing this application on behalf of another person, Turriff Medical Practice will require their authorisation before we can release the data to you. The person whose information is being requested should sign this form. If the patient is a child i.e. under 16 years of age the application may be made by someone with parental responsibilities, in most cases this means a parent or guardian. If the child is capable of understanding the nature of the application his/her consent should be obtained or alternatively the child may submit an application on their own behalf. Generally children will be presumed to understand the nature of the application if aged between 12 and 16. All cases will be considered individually.

APPLICANT DETAILS

Name:	Date of Birth:
Address:	Telephone Number:
***Email Address:	Mobile Number:

***** consent required for us to communicate with you by email, see overleaf***

☐ **My Own Medical Records**

Name / Address / Date of Birth:

☐ **Medical Records of the Person Detailed Below**:

Name / Address / Date of Birth:

☐ **Medical Records of the Child Detailed Below**:

Name / Address / Date of Birth:

TYPE OF REQUEST *Please specify your preference by placing a tick in the appropriate box*

☐	*Summary of Medical Records*
☐	*Immunisation Summary*
☐	*Results : Date / Type of Result:*
☐	*Medical Records Dates From …… to ……*
☐	*Part(s) of Medical Records* ***Please detail exactly what you are looking for***

CONSENT

Tick Which Applies:-

☐ **Medical Records Release**

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the record(s) referred to overleaf under the terms of the General Data Protection Regulations.

☐ ****Email Communication**

I confirm that if I have provided email contact details that I am happy to be contacted by this method and that I am aware that this is not a secure method of communication and will not hold Turriff Medical Practice liable for any data breach in regard to emails regarding my Subject Access Request.

☐ I am the Patient

☐ I have been asked to act by the patient detailed over leaf and who has signed the authorisation section

☐ I am the parent/guardian of a patient who is between the age of 12 years old and 16 years old who has signed the authorisation section

☐ I am the parent/guardian of a patient who is under 12 years old who is unable to understand the request

Signature of Applicant:	Date:

AUTHORISATION OF PATIENT IF REQUEST MADE BY A THIRD PARTY

I authorise Turriff Medical practice to release Personal Data requested relating to me to the above applicant to whom I have given my consent to act on my behalf.

Signature of Patient:	Date:

Signature of Child:	Date:

COLLECTION OF RECORDS

Turriff Medical Practice will only provide the medical records to the patient to whom they relate.

We will contact you either by email, SMS or telephone to advise when the records are ready for collection. We will retain for two months after notifying you they are ready for collection.

You will be asked to sign a collection form and confirm you are responsible for the security of the information once it leaves the Medical Practice.

ID must be provided again at time of collection.

TO BE COMPLETED BY RECEPTION STAFF		**TO BE COMPLETED BY REPORTING DESK**	
Date Request Received:		Request to GP:	
Patient Advised Timescale for completion:		Date Records Ready:	
Patient Advised ID Required if collecting:		Patient Contacted by Phone/Email/SMS:	
Receipt of Documentation Recorded in Vision		Patient Advised to Collect themselves:	
		Patient Advised to Bring ID when Collecting:	