

**DATA SUBJECT ACCESS REQUEST**

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| --- |
| Section 1 – Your Details |
| Please make sure you use your formal name in this section |
| Mr Mrs Ms Dr | Other |  | Surname |  |
| First Name |  |
| Address  |  |
|  |  |
| Date of Birth |  |
| Telephone Number |  | Email address |
| How would you like to be informed when the records are ready to collect? |
| Telephone preferred | Yes | Email preferred | Yes |
| Section 2 – Information you require  |
| It would be helpful for us if you can detail the reason for the request below please. |
|  |
| Please complete the details below detailing exactly what you would like copies of: |
| 1. | Please provide me with copies of my medical records for the following period |
| From: |  | To: |  |
| 2. | Please provide me with copies of all records relating to a certain condition/incident  |
| Condition/incident: |
| Section 3 – Signature |
| Signed |  | Date |  |
| Please hand this form to the receptionist. You will be required to bring in photo ID and sign a form to acknowledge receipt and responsibility for your record when you collect. |
|  |
| For Practice Use ONLY |
| Action | Signed | Date |
| **Data Extracted** |  |  |
| **Data Checked** |  |  |
| Patient advised ready to collect |  |  |