

Subject Access Request Form

Application form to access personal data

Please read the following instructions before completing the form.

Under the Data Protection laws, you have a right of access to information relating to you, subject to certain exemptions.

To enable us to process your request, you are required to provide us with satisfactory evidence of identity.

If you are requesting a copy of your own health records, you need to enclose with the completed form:

- A copy of your photographic ID such as a Driving Licence or Passport

Where you are requesting the records of another person, you are expected to provide satisfactory proof of evidence showing that you have adequate authorisation which entitles you to act on their behalf or in their best interest. An explicit consent from the individual i.e., signed and dated within the last three months is required. Additional documents to be provided with the completed form include:

- A copy of their photographic ID such as a Driving Licence or Passport
- An explicit consent from the patient i.e., signed and dated within the last three months, where you are requesting for the records of another person

If you are requesting records on behalf of an individual under the age of 16, you need to enclose:

- A copy of your photographic ID such as a Driving Licence or Passport
- Proof of parentage/legal guardianship such as a Birth Certificate

The statutory timeframe for processing a request for information is 30 calendar days. To enable us to process your request within the required time, please enclose all relevant documents with your request, we will accept copies sent to us via email.

You can apply for your records either by email, post, telephone call, or in person to the applicable hospital (visits are subject to restrictions during the pandemic). The contact details of each of our hospitals are available on our [external website](#).

Alternatively, you may contact the corporate Information Governance team [here](#).

If you do not have a valid government-issued photo identity documents, we may accept a letter from your local doctor or General Practitioner, stating your name, address, date of birth, duly signed and dated by them.

| Section 1: Details of the Data Subject | |
|---|--|
| Details of the person whose records are being requested | |
| Surname: | |
| Former name: | (if applicable) |
| Forename(s): | |
| Title: | |
| Date of Birth: | |
| Hospital/s Attended: <i>(For CHG Staff only)</i> | |
| CHG site worked at: | |
| Mobile phone number: | |
| Email address: | |
| Current postal address: | |
| Details of your request (Further information about what is being requested): | e.g. medical records related to appendicitis surgery in March 2018 |
| Section 2: Declaration and Authorisation | |
| <p>I am applying to access my records under the terms of the Data Protection Act. (If you are requesting records on behalf of another person, please complete Section 3)</p> <p>I understand that I will be required to provide proof of my identity.</p> <p>I declare that the information I have given on this form is correct to the best of my knowledge and that I am the person named above.</p> <p>Signature:</p> <p>Date:</p> | |

| Section 3: For Third Party Request Only | |
|---|---|
| I am applying on behalf of the person named above to access their records under the Data Protection Act 2018. | |
| I understand that I will be required to provide proof of my identity. | |
| Your name (BLOCK CAPITALS): | |
| Your signature: | |
| Date: | |
| Authorisation from Patient/Data Subject | |
| I give my consent to the above-named person to be supplied with copy of my records as stated above. | |
| Signature: | |
| Date: | |
| *If acting on behalf of the data subject because of their mental capacity then please tick the applicable box below instead. | |
| I am acting on behalf of the data subject who lacks capacity to consent as defined by the Mental Capacity Act 2005. | |
| or | |
| I hold a Lasting Power of Attorney (LPA) / I have been appointed as an independent Mental Capacity Advocate to act on behalf of the data subject (delete as applicable) and have attached evidence. | |
| or | |
| I have parental responsibility and the data subject is under the age of 12 years or either | |
| <input type="checkbox"/> | Lacks capacity to understand the request |
| <input type="checkbox"/> | Has consented to the request |
| <input type="checkbox"/> | The data subject is between 16 and 18 years of age and lacks capacity |
| If you are requesting personal records of a deceased person, please email: Information.Governance@bmihealthcare.co.uk | |