**APPLICATION FOR ACCESS TO MEDICAL RECORDS (SARS)**

**Details of records to be accessed:**

|  |  |
| --- | --- |
| Patients name |  |
| Date of birth |  |
| Telephone number |  |
| Address  |  |

**Details of person who wishes to access the records, if different to above:**

|  |  |
| --- | --- |
| Surname  |  |
| Forename(s) |  |
| Relation to patient |  |
| Telephone number |  |

Declaration: I declare that the information provided by myself is correct to the best of my knowledge and that I am entitled to apply for access to health records referred to above under the terms of the data protection Act 1998.

**Tick and fill the following statement that applies:**

* I am the patient. The reason for my request is ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_
* I have been authorised to act on behalf of the patient and attached the patient’s written reason and consent for this request.
* I am acting in Loco Parentis as the patient is under the age of 16 and the patient is incapable of understanding the request/or has consented to me making this request. The reason for the request is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I am the deceased patient’s personal representative requested the medical records and attached confirmation from the department of which this information will be handed to.

**Please complete the section that applies best:**

|  |  |
| --- | --- |
| I require all medical records  |  |
| I require medical records between specific dates or for a specific condition ( please give details) |  |

**SIGNATURE:­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_**