Proof of Identity Seen (Passport or Driving Licence)	
Date	
Signed	

SUBJECT ACCESS REQUEST TO TWYFORD SURGERY

You can use this form to request access to the personal data that we hold about you, in line with the General Data Protection Regulations (GDPR), Chapter 3, Article 15 (Recitals 63 & 64).

You can also use this form to request access to the records on behalf of someone else, as long as you are legally allowed to act on their behalf. This includes:

- Making a request for a child
- Making a request for someone that you have Power of Attorney for

You should fill in all sections of the form that apply to you.

DETAILS OF THE PATIENT THIS REQUEST IS ABOUT

TITLE	
SURNAME	
FIRST NAME(S)	
FORMER SURNAME	
DATE OF BIRTH	
GENDER	
NHS NUMBER (IF KNOWN)	
CONTACT NUMBER (DAYTIME)	**Home:** **Mobile:**
EMAIL ADDRESS	
HOME ADDRESS (INCL POSTCODE)	

If the patient has been known by a different name or has lived at a different address during the time span of your enquiry then please give details below:

	DATE FROM	DATE TO
PREVIOUS NAME		
PREVIOUS ADDRESS (1)		
PREVIOUS ADDRESS (2)		

WHAT INFORMATION DO YOU REQUIRE?

Full Medical Records: YES/NO

Online Access via Patient Access and/or NHS App: YES/NO

Specific Information: Test Results/Consultations/Letters etc (Please detail below)

Specific date range: _____

DECLARATION

Unless there is a Health & Welfare Lasting Power of Attorney or the request is being made on behalf of a child under 13, everyone named on this form must sign.

I confirm that the information I have supplied in this request is correct, and I am the person to whom it relates.

SIGNATURE: ……

PRINT NAME: ……

DATE: ……

ONLY COMPLETE THIS PAGE IF YOU ARE MAKING A REQUEST ON BEHALF OF SOMEONE ELSE

If you are not the patient, but acting on their behalf, please complete the details below. We need to know what gives you the authority to act on their behalf, so please state your relationship with them, for example, parent, guardian, solicitor or holder of Power of Attorney.

FULL NAME	
RELATIONSHIP TO THE PATIENT	
CONTACT NUMBER	
EMAIL ADDRESS	
ADDRESS	

I confirm that the information I have supplied in this request is correct, and I am acting on behalf of the patient. I have enclosed the relevant proof of authority.

SIGNATURE: ……

PRINT NAME: ……

DATE: ……