The Riverside Partnership

Patient Access to Medical Records
Subject Access Request

Access to Health Records under the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018)
Patients authority consent form for release of health records
(Manual or Computerised Health Records)

Use this form to request copies of patient medical records. For online access, use the 'Online Access to Your Health Record' form.

Identity of individual about whom information is requested

Full Name	
Current Address	
Date of Birth	
Contact phone number	
NHS Number (if known)	
E-mail address (optional)	

You are not required to give a reason for applying for access to your health records however, it would be helpful if you could provide some detail informing us of periods and elements of your health records you require, along with details which you may feel have relevance i.e. consultant name, location, written diagnosis and reports etc.

Dates and types of records:

RIVERSIDE

Please tick the appropriate box identifying whether you, or a representative on your behalf, is applying for access.

I am applying for copies of my health records.	

I would like my records emailing to me		I would like paper copies	

If you are the patient's representative, please give details here:

Name and Address of representative	
Contact number and E-mail	
Signature	

Signature of applicant	
Print Name	
Date	

For Practice Use Only:

Identity verified through	☐ Passport ☐ Driving License ☐ Proof of Residence ☐ Other: Please State:	
Name of Verifier		Passed to PA for Processing: ☐ Yes
Sign up process completed by		Date: