Dr Barbara Allan Dr Matt Joslin Dr Simon Wilkins

Patient Subject Access Request

Patient name: ……………………………………… Patient DOB: …………………...

Former name(s): ……………………………………

Address: ……………………………………………………………………………….

Phone number: …………………………………….

Identification received: Personal vouch / Passport / Driving Licence (*Please circle one*)

Nature of the medical information required (please be as precise as possible):

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Date the request for medical information was made (practice stamp if possible): ………………………

Request taken by (staff member name): …………………………………………………..

Has the patient been made aware that the medical information will be ready for collection from the surgery within one calendar months' time? Yes / No

Has the patient been made aware that once the medical records are supplied to them, we are no longer liable for what happens to that paperwork? Yes / No

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