**MID ULSTER HEALTHCARE**

**Subject Access Request Form**

|  |
| --- |
| Mid Ulster Healthcare respects the rights of individuals to have copies of their information wherever possible. |
| **Personal information collected from you by this form, is required to enable your request to be processed, this personal information will only be used in connection with the processing of this Subject Access Request.** |
| **Charges Payable:** In accordance with legislation no fee will be charged for your request, unless the request is manifestly unfounded or excessive, especially if it is repetitive. Before any further action is taken, we will contact you with details of our “reasonable administrative charges” in order to comply with your request. |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PLEASE COMPLETE IN BLOCK CAPITALS – Illegible forms will delay the time taken to respond to requests.** | | | | | | | | | | |
| **1 Details of Patient/Clients/Staff Members records to be accessed (please complete one form per person).** | | | | | | | | | | |
| Surname | | | | | | | | | | Date of Birth |
| Forename(s) | | | | | | | | | | Current Address  Full Postcode |
| Any former names (if applicable) | | | | | | | | | |
| Telephone Number | | | | | | | | | | Previous Address (if applicable)  Full Postcode |
| NHS Number (if known/relevant) | | | | | | | | | |
|  |  |  |  |  |  |  |  |  |  |
| If further details are available please include in a separate covering letter. | | | | | | | | | | |
|  | | | | | | | | | | |

|  |  |
| --- | --- |
| **2 Details of Records to be Accessed** | |
| In order to locate the records you require please provide as much information as possible. Please list the department or services you have accessed that you require records from: i.e. Healthcare or Human Resources etc (Continue on a separate sheet if required). | |
| Records dated from | Department of services accessed |
| / / to / / |  |
| / / to / / |  |
| / / to / / |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **3 Details of Applicant (Complete if different to patients/clients/staff members details)** | | | | | | |
| Full Name | | | |  | | |
| Company Name (if applicable) | | | |  | | |
| Relationship with individual who’s records have been requested | | | |  | | |
| **Print Name** |  | **Signed (Applicant)** |  | | **Date** | / / |

**Please complete and return by hand to**

**The Practice Manager / Assistant Practice Manager**

**Mid Ulster Healthcare**