Cleveland Clinic

Patient Medical Records – Subject Access Request Form

1. Details of the Person the Request is About (Data Subject)			
Title:	**Miss / Mr / Mrs / Ms / Mstr / Mx /**	Given Name(s):	
Family Name:		Previous Family Name:	
Date of Birth:		Gender Identity:	☐ Female ☐ Male ☐ Trans ☐ Other
Current Home Address (1):		Mobile Telephone:	
		Home Telephone:	
		Email Address:	
Post-Code:		Jersey SSD Health Insurance Number:	

2. Previous Home Address (Please provide residence address for the period to which the request refers. Further space is provided on the next page)			
Previous Home Address & Post-Code (2):		Previous Home Address & Post-Code (3):	
Date From / To:	/	Date From / To:	/

3. Third Party Request Details (If the information is being requested on behalf of the data subject)			
Title:	**Miss / Mr / Mrs / Ms /**	Given Name(s):	
Family/Company Name:		Date of Birth:	
Address & post-Code:		Mobile Telephone:	
		Home Telephone:	
		Email Address:	

4. Third Party Relationship to the Data Subject

☐ I am the patients personal representative (please attach proof of relationship, see section 5 for further details

☐ I am the executor of the estate (please attach confirmation of your appointment)

☐ I have been designated the administrator of the data subject (please attach confirmation of your appointment)

☐ I have a claim arising from the data subjects death (please provide details of this claim below)

5. Proof of Identity (for Data Subject and/or Third Party)

It will be necessary to confirm the identity of **ALL** parties included on this form. Please supply an original document from sections **A** and **B** below and **ALL** relevant documents from Section **C** and **D** with the application if relevant with this form to be checked and verified (copies are not retained):

Section A:	☐ Passport ☐ Full Driving License ☐ National Identity Card
Section B:	☐ Utility Bill ☐ Bank/Credit Card Statement ☐ Income Tax/Social Security Notice
Section C:	☐ Birth Certificate ☐ Marriage Certificate ☐ Deed Poll Certificate ☐ Other Legal
Section D:	Confirmation that a third party can access the records of the data subject: ☐ Proof of Relationship to subject (ie personal representative) ☐ Data Subject Signed Consent (see section 8) ☐ Confirmation of appointment as executor of the estate of a deceased data subject ☐ Confirmation of appointment of administrator of a deceased data subject

6. Information Being Applied for by the Data Subject ☐

☐ I am applying for access to view my complete health record

☐ I am applying for access to view part of my health record (please give dates below)

☐ I am applying for copies to be provided of my complete health record

☐ I am applying for copies to be provided of part of my health record (please give dates below)

Date(s) From:		Date(s) To:	
Types of records you require:	☐ Consultations ☐ Results/Reports ☐ Correspondence ☐ Referrals ☐ Other		
How do you wish to receive it?	☐ Email ☐ Post ☐ Other		
Your Usual GP:			

Reason for your request: You do not have to provide a reason for applying for access to your health records. However, to help us save time and resources, it would be helpful of you could provide details in the space below on the elements or specific parts of your health record you require, along with any other details which you may feel have relevance to your request.

7. Comments or Further Details In Relation to this Subject Access Request ☐

8. Data Subject and Third Party Representative Declaration ☐

Your declaration to us:

- I confirm that all the information provided in this form is accurate and true to the best of my knowledge.
- I hereby consent to the Practice providing this information to me or where the form has been completed, to my appointed Third Party Representative named in this form above and signed by them below in accordance with Data Protection Law.

Signed (Applicant):	Print Name:	Dated:
Signed (Third Party):	Print Name:	Dated:

For Practice Use Only

Date Form Received:		Received By:	
Data Subject ID Verified:		Third Party ID Verified:	
Reason for Request Validated:		Further Validation Requested:	
Information Reviewed by GP:		Information Provided:	
SAR Closed Date:		SAR Documents Scanned Date:	