APPLICATION TO APPLY FOR ACCESS TO YOUR MEDICAL OR HEALTH RECORD UNDER THE DATA PROTECTION ACT 1998

To be completed by person applying for access to the medical record **Details of the Data Subject** **(e.g. the applicant)**	**Verification process to be completed by the Practice**
Your Full Name	Date request received
Your Full Address	Date fee received
Your Date of Birth	Original documents and proof of identification received and verified
Daytime telephone number where you may normally be contacted	Data subject's GP
Date application made	Date acknowledgement of request sent
Are you requesting full or partial access to the record? Please enter date if requesting partial access to a particular period of the record	Date record checked for third party disclosure Name of Data Controller: Date Authority to release information received (i) From the data subject Date Authority to release information received (ii) From the Data Controller

If you have given your permission for another person to access your medical record please answer the following questions

Full name of the person you have nominated:
Their address:
Their daytime telephone number:
Their relationship to you:

Declaration

I declare that the information given by me on this form is correct and that I am entitled to apply for access to my health or medical record under the terms of the Data Protection Act 1998 and that I am the *applicant/parent/guardian (*please delete as appropriate)

Signed _____ Dated _____