Hello@iSleepClinic.com

Health Quant Limited
Company Registration Number: 11815643

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Subject access request

You will appreciate that health data relating to any individual is highly confidential and the Practice must ensure that it releases such data only to the person to whom it relates, or to a person authorised to act on his/her behalf. Please complete this online Request Form as fully and accurately as possible to enable us to locate the exact data you require.

The General Data Protection Regulations give you the statutory right of access to any information, manual (paper) or computerised. You may wish to authorise someone else to make your application on your behalf. If you have parental responsibilities, you may make an application to see your child's notes.

You do not have to give a reason for applying for access to your General Practice records. If you do not need access to your entire records, it would be helpful if you would inform us of the periods and parts of your health records that you require, along with details which you may feel have relevance (e.g. dates)

Timescale: The Practice will deal with your request as quickly as possible. The information should be available to you within 28 days of receipt of your accurately completed form and confirmation of consent. Under certain circumstances, this period can be extended to 3 months, but we will keep you informed of the progress of your request during this extended period.

Proof of identity: Two forms of identity must be provided (one of which must be photographic). This is to ensure no information is released to unauthorised individuals. The table below outlines the proof of identity required.

TYPE OF APPLICATION	IDENTIFICATION REQUIRED
Patient applying for their own *Can be waived if the applicant is known to the Staff Member accepting the request.*	One which must be photographic e.g. passport. One containing individuals name and address.
Third Party Applying. *Consent of Patient will be required* ***BEFORE*** *the request will be processed.*	One containing Third Party name and address. One must be Photographic ID of Third Party.
Applying on behalf of a child *The age of consent is 12.* *We will* ***ALWAYS*** *obtain consent for release of records from a child age 12+ to <16 if a third party is making request.*	One which must be Child's birth certificate, & Photographic ID of person with parental rights.

If you are completing this application on behalf of another person, the Practice will require their authorisation before we can release the data to you. The person whose information is being requested should sign the relevant section within the online form. If the patient is a child (i.e., under 16 years of age) the application may be made by someone with parental responsibilities – in most cases this means a parent or guardian. If the child is capable of understanding the nature of the application, his/her consent should be obtained or, alternatively, the child may submit an application on their own behalf. Children will, generally, be presumed to understand the nature of the application if aged between 12 and 16. All cases will be considered individually.

Subject Access Request Form

Applicant Details

Full Name …….

I am requesting

- My own medical records
- The medical records of another adult
- The medical records of a child

Email ……..

Date of birth ……

Please use format day/month/year (e.g. 12/05/1979)

Preferred Phone number ……..

Type of Request

I wish to request

- Copy of Medical Records
- Partial Medical Records
- Other (Please Specify)

Consent

Tick which applies

- I am the Patient
- I have been asked to act by the patient as detailed and who has signed the authorisation section
- I am the parent/guardian of a patient who is between the age of 12 years old and 16 years old who has signed the authorisation section
- I am the parent/guardian of a patient who is under 12 years old who is unable to understand the request

Signature of Applicant

Privacy Policy

This form collects your name, date of birth, email, other personal information and medical details. This is to confirm you are registered with the Practice, to allow the Practice team to contact you and also to update your medical records held by the Practice. Please read our Privacy Policy to discover how we protect and manage your submitted data.

- **I consent to the practice collecting and storing my data from this form.**

PLEASE EMAIL THE COMPLETED FORM ALONG WITH YOUR IDENTITY DOCUMENTS TO:
Hello@iSleepClinic.com