CEDAR CROSS MEDICAL CENTRE

APPENDIX 2 – APPLICATION FORM FOR SUBJECT ACCESS REQUEST

The Data Protection Act 2018/GDPR provide you as a data subject with the right to receive a copy of the data/information Cedar Cross Medical Centre holds about you. You can request for copies of information held about you or authorise a third party to request for information held about you.

Please complete the necessary section on this form if you wish to see the information the Practice holds about you and in order for the Practice to process your request, you will also need to provide proof of your identity.

Your request will be processed within 1 calendar month upon receipt of your application; including receipt of any further information the Practice may ask you to provide to enable the Practice to respond to your request. This may include, proof of identity, confirmation of your consent where request are made on your behalf by a third party and payment of a fees if required. A fee may be charged where request is excessive, complex, manifestly unfounded or repetitive in nature in order to cover administrative costs.

Section 1: Data Subject/Patient Details

Please fill in your details (the data subject). If you are not the data subject and you are applying on behalf of someone else, please complete section 2 on behalf of the data subject.

Title: Mr ☐ Mrs ☐ Ms☐ Miss☐ Other -
Surname/ Family Name:
First Name(s)/Forenames:
Date of Birth:
Address: Post Code:
Telephone Number:
Email:
NHS Number (if known)
I am enclosing the following copies as proof of identity: Birth Certificate ☐ Driving Licence ☐ Passport ☐ An official letter to my address ☐
If none of these are available please contact the Practice Manager for advice on **0151 426 5569**

Section 2: Contact Details of Third Party (if applicable)

Please complete this section of this form with your details if you are acting on behalf of someone else (i.e. the data subject).

If you are NOT the data subject, but a third party authorised on their behalf, you will need to provide evidence of your identity as well as that of the data subject and proof of your right to act on their behalf

Title: Mr ☐ Mrs ☐ Ms☐ Miss☐ Other -
Surname/ Family Name:
First Name(s)/Forenames:
Address: Post Code:
Telephone Number:
Email:
I am enclosing the following copies as proof of identity: Driving Licence ☐ Passport ☐ Third Party proof of identity ☐ – please list type
If none of these are available please contact the Practice Manager for advice on: **0151 426 5569**
What is your relationship with the data subject? (e.g. parent, carer, legal representative)
I am enclosing the following copy as proof of legal authorisation to act on behalf of the data subject: Letter of authority from the data subject ☐ Lasting or Enduring Power of Attorney ☐ Evidence of parental responsibility ☐ Other (give details) ☐

Section 3: Request for Personal and Confidential Data (PCD)

In order to help the Practice process your request in a timely manner; please complete as much detail as possible.

Please provide me with a copy of all records relating to a specific treatment from (i.e. December 2017 – January 2018):
Please provide me with a copy of records relating to the incident specified below from: (i.e. Nov 2017-Dec 2017)
Please provide me with a copy of my consultation from (i.e. January 2017 – March 2018):
OTHER – Please provide me with
Please provide me with a copy of all records held: Reason for requesting medical records:

Section 4: Data Subject/Third Party (authorised person) Declaration

<table>
<tr><td colspan="2">Data Subject Declaration:

I declare that the information provided on this form is correct to the best of my knowledge and I am the person to whom it relates. I understand that Cedar Cross Medical Centre will take necessary steps to confirm proof of my identity/authority and it may be necessary to obtain further information from me in order to respond to this subject access request.
(Delete as appropriate)I hereby authorise _____
to act on my behalf and be granted access to the PCD requested in section 3 of this form.</td></tr>
<tr><td colspan="2">Name:</td></tr>
<tr><td>Signature:</td><td>Date:</td></tr>
<tr><td colspan="2">OR

Authorised person/Third Party – Declaration (if applicable):

I confirm that I am legally authorised to act on behalf of the data subject.

Cedar Cross Medical Centre will take necessary step to confirm proof of my identity/authority and it may be necessary to obtain further information in order to comply with this subject access request</td></tr>
<tr><td colspan="2">Name:</td></tr>
<tr><td colspan="2">Relationship with Data Subject:</td></tr>
<tr><td>Signature:</td><td>Date:</td></tr>
</table>

Please send your completed form and proof of identity to:

Practice Manager
Cedar Cross Medical Centre
Whiston PCRC
Old Colliery Rod
Whiston L35 3SX