

Dr Manu K Lamba
MBBS, LRCP, LRCS, LRCPS, DRCOG
Dr Amrit M Lamba
MBBS, MSc, DRCOG, MRCGP

Colindale Medical Centre
61 Colindeep Lane
London NW9 6DJ
T 020 8205 6798
colindalemedicalcentre.nhs.uk

APPLICATION FORM FOR ACCESS TO MEDICAL RECORDS (SAR)

In accordance with the UK General Data Protection Regulation (UK GDPR)

Patient details

First name	
Last name	
Date of birth	
Address	
Phone number	
Email	

I am applying for access to view the records only	<input type="checkbox"/>
I am applying for an electronic copy of the medical record	<input type="checkbox"/>
I am applying for a printed copy of the medical record	<input type="checkbox"/>

Please specify what information you are requesting:

I would like a copy of records between specific dates only (please give dates below)	<input type="checkbox"/>
I would like a copy of records relating to a specific condition / specific incident only (please detail below)	<input type="checkbox"/>
I would like a copy of all the electronic records (held on computer)	<input type="checkbox"/>
I would like a copy of all the electronic and paper records since birth	<input type="checkbox"/>



Reason for access:

I am the patient	<input type="checkbox"/>
I have been asked to act by the patient and attach the patient's written authorisation	<input type="checkbox"/>
I have full parental responsibility for the patient and the patient is under the age of 18 and: <ul style="list-style-type: none"> • Has consented to my making this request, or • Is incapable of understanding the request (delete as appropriate) 	<input type="checkbox"/>
I have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	<input type="checkbox"/>
I am acting <i>in loco parentis</i> and the patient is incapable of understanding the request	<input type="checkbox"/>
I am the deceased person's personal representative and attach confirmation of my appointment (Grant of Probate / Letters of Administration)	<input type="checkbox"/>
I have written, and witnessed, consent from the deceased person's personal representative and attach Proof of Appointment	<input type="checkbox"/>
I have a claim arising from the person's death (please state details below)	<input type="checkbox"/>

Declaration

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the UK [Data Protection Act 2018](#). You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Before returning this form, please ensure that you have signed and dated the form, are able to provide proof of your identity or alternatively confirmed your identity by a countersignature, enclosed documentation to support your request (if applicable). Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

In accordance with the UK GDPR, patients are entitled to receive a response within the maximum given time frame of one calendar month from the date of submission of the SAR. There is no facility for immediate access. **You will be telephoned when the copies are ready for collection or posting.**

Applicant signature		Date	
I confirm that I give permission for the Organisation / Parent to communicate with the person identified above regarding my medical records			
Patient signature		Date	