For staff use
When taking request from patient please check
Two forms of ID verified (one photo ID): Y/N or STAFF MEMBER VOUCHES FOR PT ID Y/N

Staff member's name …… Date …….

HIGH PASTURES SURGERY

SUBJECT ACCESS REQUEST

This form must be completed by all patients requesting copies of their clinical records and passed to the Admin Team immediately for processing.

1. Print name
   ……
2. Address
   ……
3. Telephone No.
   ……

Please detail notes required and reason below

- ✓ I confirm that I will take ownership of any copy records provided to me by High Pastures Surgery
- ✓ I confirm I have no concerns regarding my clinical care
- ✓ I confirm I have no concerns regarding my clinical records being inaccurate
- ✓ I confirm that any onward transfer to 3rd parties is my responsibility and that High Pastures Surgery has no liability for the onward transfer of the requested records.
- ✓ I confirm that any documents provided are then my responsibility to keep secure.

Patient Signature …… Date ……..