**THE QUARTER JACK SURGERY**

**PATIENT AUTHORITY CONSENT FORM**

ACCESS TO HEALTH RECORDS UNDER THE GENERAL DATA PROTECTION REGULATION 2018

(SUBJECT ACCESS REQUEST)

Patient’s authority for release of health records or release of information of a child (Under 16)

(Manual or Computerised Health Records)

**Please print all details and use dark ink**

**To: The Quarter Jack Surgery**

Date ……………………………………………………

I am requesting information regarding a child’s health records/ applying for access to view a child’s health records/ applying for copies of a child’s health records/.

(delete as appropriate)

\*Please give as much detail as possible of what is requested

…………………………………………………………………………………………………………………

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**Child’s details:**

Full name .. …………………………………………………………………………………………………….

Date of birth………………………………………………NHS no. (if known)………………………………..

Current address………………………………………………………………………………………………….

Former address………………………………………………………………………………………………….

**Your details:**

Full name . …………………………………………………………………………………….……………….

Current address………………………………………………………………………………………………….

Contact telephone number ……………………………………………………………………………………...

Relationship to child…………………………………………………………………………………………….

Signature………………………………………………………………………………………………………..

**We will need to see Photo ID and establish Parental Responsibility before release of any information.**

Photo ID………………………………………………………………………………………………………

Proof of Parental Responsibility………………………………………………………………………………

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| Scan to notes under XaBpx(Consent status) | Date: | Scanned by: |