Tadley Medical Partnership Subject Access Request

Please use this form to request copies of your General Practice medical record which will be sent to you via secure email

First Name	
Last Name	
DOB	
Email Address	
Telephone Number	
Home Address	
Please Select	Full Record
	Extract*
*Please inform us of any data ranges and specific parts of your record you require.	
I confirm I am the data subject named above (the person the information is about) Signature of patient or patient's representative: I have parental responsibility (please complete as appropriate) Full Name: I have legal Power of Attorney (Health and Welfare) Full Name:	
Date:	
Consent for children under 16: Everyone aged 16 or over is presumed competent to give their own consent. If a child under 16 has sufficient understanding of what is proposed they may complete this form themselves. If a child under 16 is not legally competent, somebody with parental responsibility should sign the form of their behalf. Consent for patients with a legal Power of Attorney for Health and Welfare: The person with Power of Attorney should sign this form on behalf of the patient.	