PLEASE RETURN COMPLETED FORM TO:
Subject Access Request Department – Oxford Rd
Manchester Royal Infirmary
Oxford Road, Manchester
M13 9WL. Tel: 0161 701 1303/1304/1316
sar.request@mft.nhs.uk

NHS
Manchester University
NHS Foundation Trust

Right of Access - Subject Access Request Form: PART 1

If you are the patient requesting access to your own records, please complete part 1 only.
If you are NOT the patient but are applying on behalf of the patient, please complete Parts 1 and 2.

Part 1- Patient details
(please print all details and use dark ink)

Title (i.e. Mr/Mrs/Miss/Ms) …… ……

Full Name …… ……

Former Name(s)…….. ……

Date of Birth ……..... ……

NHS Number/District Number …….. ……

Current Address …… ……

……

Telephone number (incl. area code) **(optional)** ……

Former addresses (if applicable - use separate sheet if necessary) ……

I am applying for **access to view my health records in person / copies of my health records**
(please delete as appropriate)

Identification **(please only send photocopies).** We cannot process your application without proof of identity. Please indicate which of the following identification documents are enclosed

Photo Driving Licence **OR** Passport / Birth Certificate

And additional proof of address e.g. utility bill

I am applying to access my health records held at:

Main Hospital……

Department/Ward/Clinic ……

Signed…… Date ……..

If you are not the patient, but are applying on behalf of the patient, please also complete Part 2.

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Right of Access - Subject Access Request Form: PART 2

Parent / Guardian / Representative acting on behalf of the patient

Please state your relationship to the patient ……...
(please attach copies of all relevant legal documentation where applicable)

Your Name ……

Your Address……..

……..

Please state briefly the reason why this application is being made by you ……

……..……...

..……

Your Signature……

Name (in block capitals) ……...

Identification **(please only send photocopies)**. We cannot process your application without proof of identity. Please indicate which of the following identification documents are enclosed

Photo Driving Licence **OR** Passport / Birth Certificate

And additional proof of address e.g. utility bill

The Patient Consent section below must be completed and signed by the patient where appropriate, in order that the Trust can release the information requested.

I (the patient) give permission for the individual named below to submit this request on my behalf, and for all correspondence to be sent to them.

Patient Name (in block capitals) ..……..

Patient Signature ……..……..

Name of the person acting on behalf of the patient ……..……

Address of person acting on behalf of the patient ……..…..

…… Postcode……

Relationship to patient……..