FULL CLINICAL RECORD ACCESS APPLICATION FORM
Data Subject Access Request (DSAR)

Requesting Full Clinical Access to your Medical Record:
To request full access to your medical record, all patients and authorised third parties must read the information below and complete the attached Data Subject Access Request (DSAR) application form.

In the first instance, your GP medical record will be made available via online services. If you are unable to use online services, you can request paper copies of your GP medical record. These will be printed for you to collect from reception with valid ID.

There are occasions when your GP may firmly believe that it is not appropriate to share all the information contained in your medical record, such as information likely to cause harm or distress.

What can you view when you have Full Clinical Access via online services?

- All entries on your GP medical record
- View or Cancel Appointments
- Test Results
- Medications
- Allergies
- Immunisations
- Letters and Attachments

Before you apply for full online record access:

- You must already have an online account.
- You must have valid photographic identification attached.

Things to consider:

Forgotten History
There may be something you have forgotten about in your record that you might find upsetting.

Abnormal Results or Bad News
If you have access to your medical record, you may see something that the Clinician has not yet been able to discuss with you.

Coercion
If you think you may be pressured into sharing details from your record to someone else against your will, it is best that you do not register for online access at this time. Should your circumstances change in the future once registered and you no longer wish to have access or you feel there is a risk of someone accessing your record without consent, please contact the medical centre immediately.

Misunderstood Information
The information within your record includes medical terminology and abbreviations written by Clinicians and may not be easily understood.

Information about someone else
If you notice something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the medical centre as soon as possible.

Can I alter the record?
No. This is a ‘read only’ facility. You can however, print off details to take to a hospital appointment etc. If you believe that there is something that needs to be changed, you will need to contact the medical centre.

What if I don’t want to view my full medical record?
If you do not wish to view your full medical record, you do not need to complete this form. Your decision will not affect your care in any way.

What about security?
It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone, then you should change your password immediately. If you are unable to change your password, you can contact the medical centre and they will remove your online access and reset your password.
If you print out any information from your record, it is your responsibility to keep this secure. If you are worried about keeping printed copies of your record safe, we recommend that you do not make copies at all. It is a contractual requirement for all GP surgeries to provide online access. Westbourne Medical Centre is not responsible for the specification or security of NHS systems that have been approved as suitable. Please be aware no online system is 100% secure. Record access is supported by the NHS.

To apply for full access to your medical records please complete the application form and this should be returned to reception with photo identification. If someone is applying on your behalf, we will also require valid ID from them. It can take up to 30 days to process this application, in the case of complex or multiple requests, we have the right to extend the response time by a further two months and this will be communicated to you.

Westbourne Medical Centre has the right to remove your online access if you do not use it responsibly or if there is evidence that access may be harmful to you.

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I confirm I have read and understood the information above and overleaf. I understand that it may take up to 30 days to process this request.

PLEASE COMPLETE THE APPLICATION FORM IN BLOCK CAPITAL LETTERS

Section 1: Patient Details

Surname		**Title (Mr, Mrs, Ms, Dr)**	
Forename		**Date of Birth**	
Full Address		**NHS Number (if known)**	
Mobile Number		**Email**	

Section 2: Record Requested
(Tick one box)

☐ I already have an online account and accept that I will access my record via this service.

OR

☐ I am unable to use online services and require paper copies of my record*****

***For paper copies only**
(Tick one box)

	Please provide me with a copy of records between the dates specified below:
	Please provide me with a copy of records relating to the incident specified below:
	Please provide me with a copy of records relating to the condition specified below:
	Please provide me with a copy of all records held:

Section 3: Details of Applicant

Enter details of applicant if different from Section 1

Surname		**Title (Mr, Mrs, Ms, Dr)**	
Forename		**Date of Birth**	
Full Address		**Relationship to Patient**	
Mobile Number		**Email**	

Section 4: Declaration

I declare that the information given is correct to the best of my knowledge.

Please tick:

- ☐ I am the patient.
- ☐ I have been asked to act for the patient and attach the patient's written authorisation.
- ☐ I have full parental responsibility for the patient (under 16) **&**
  - ☐ patient has consented to my making this request.
  - ☐ patient is incapable of understanding the request.
- ☐ 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.
- ☐ I am acting *in loco parentis* and the patient is incapable of understanding the request.
- ☐ I am the deceased person's Personal Representative and attach confirmation of my appointment (Grant of Probate/Letters of Administration)
- ☐ I have written and witnessed, consent from the deceased person's Personal Representative and attach Proof of Appointment
- ☐ I have a claim arising from the person's death (Please state details below)

Additional Information:

Signature of applicant: ..... Date: ……

You are advised that the making of false or misleading statements to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Section 5: Proof of identity

Evidence of the patient's and/or the patient's representative photo identification will be required. Please attach copies of the required documentation to this application form.

Attached (Tick one)	**Type of Applicant**	**Type of Documentation**
	An individual applying for their own record	One copy of identity required. e.g. birth certificate, passport, driving licence.
	Someone applying on behalf of an individual (Representative)	One copy showing proof of the patient's identity & one copy showing proof of the representative's identity. e.g. birth certificate, passport, driving licence.
	Person with parental responsibility applying on behalf of a child	Copy of birth certificate for child & copy of person with parental responsibility identity required. e.g. birth certificate, passport, driving licence.
	Power of Attorney/ Agent applying on behalf of an individual	Copy of a court order authorising Power of Attorney/ Agent & proof of the patient's identity e.g. birth certificate, passport, driving licence.

5B Countersignature

This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section should be completed if 5A cannot be fulfilled.

I (insert full name) .....

Certify that the applicant (insert full name) .....

Has been known to me personally as (e.g. employee, client, patient, friend etc.)

..... for..... years

and that I have witnessed the signing of the above declaration. I am happy to be contacted if further information is required to support the identity of the applicant as required.

Signed .....Date .....

Name ..... Profession .....

Address .....

.....

Contact Number .....

☐ *Form Signed (page 4)*

☐ *ID Attached / Countersigned*

☐ *Additional Documents*

FOR STAFF USE ONLY
UPDATED 14/10/2026

DSAR APPLICATION

GRANTED OR REFUSED *(circle one)*

ID checked by: ……

Received on: ……

Processed on: ……