SAR Request Form

(Releasing health records under the General Data Protection Regulations 2018)

Your full name:	
Your address:	
Date of birth:	
Contact Telephone Number:*	
Email address:*	
Solicitor's or agent's name and address (if applicable):	
GP's name and address:	

*** By providing us with your email address and/or mobile number you consent to be contacted by email and/or SMS**

Part A)

If you only require information from a **specific part of your medical history**, please specify this below.

Information/details as follows: (Please outline the information you authorise to release)

I can confirm that I give permission for the above information to be released only.

Your Signature:	
Date:	

Part B) only sign below if you require a copy of your entire record.

I understand that filling in and signing this form gives you permission to give copies of all of my GP records.

Your Signature:	
Date:	