**Subject Access Requests – Third Party**

**Date:…………………………**

**Patient Name:…………………………………………………………………………………………………**

**Date of Birth:………………………………………………………………………………………………….**

**Address:……………………………………………………………………………………………………….**

**…………………………………………………………………………………………………………………..**

**Telephone no:………………………………………………………………………………………………..**

**Declaration of Consent**

I understand that the Practice has received a request for medical information about me from:

**Name of Company / Organisation: ……………………………………………………………………..**

**………………………………………………………………………………………………………………….**

**The request is for: ………………………………………………………………………………………….**

**…………………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………….**

**Delete as applicable:**

I fully understand the purpose for which this information has been requested.

I **DO** give my express consent for the information as requested to be disclosed to:

 …………………………………………………………………………………………………………………..

I **DO NOT** give my express consent to the information as requested being sent. I understand that it is my responsibility to contact ……………………………………………………………………….. to have the request amended.

**Patient Name:……………………………………………………………………………………………..**

**Patient Signature …………………………………………………………………………………………**

**Date: …………………………………………**

**Staff Name:…………………………………………………………………………………………………**

**Staff Signature:………………………………………………………………………………………………**

**Date:…………………………………………**