

**SUBJECT ACCESS REQUEST**

**RECORD COLLECTION FORM**

This form must be completed for all collections of copies of patient records and passed to the Admin Team immediately for processing.

I, (Print name) ……………………………………………………………………………………

Confirm that I have taken ownership of the copy records provided to me by Mountsandel Medical Centre.

I confirm that any onward transfer to 3rd parties is my responsibility and that Mountsandel Medical Centre has no liability for the onward transfer of the requested records as provided to me.

Signature…………………………………………………Date…………………………….

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**For Staff use:**

Two forms of ID verified : Y/N **OR** STAFF MEMBER VOUCHES FOR PT ID Y/N

Staff Member’s Name……………………………… Date …………………………

Put for scanning to patient record.

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