**APPLICATION FORM FOR ACCESS TO HEALTH RECORDS**

**in accordance with the General Data Protection Regulation (GDPR)**

**DATA SUBJECT ACCESS REQUEST**

This form must be completed in full & signed in order for us to process your request. You must also provide proof of identity with this application.

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Maiden name** |  |
| **Forename** |  | |  | | --- | | **Title** | | **(i.e. Mr, Mrs, Ms, Dr)** | |  |
| **Date of birth** |  | **Address:** |  |
| **Telephone number** |  | **Postcode:** |  |
| **NHS number (if known)** |  | **Hospital number (if known)** |  |

**Section 2: Record requested**

The more specific you can be, the easier it is for us to quickly provide you with the records requested. Record in respect of treatment for: (e.g. leg injury following a car accident)

|  |  |
| --- | --- |
| **Please provide me with a copy of all records held** |  |
| **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:** |  |

**Section 3: Details and declaration of applicant**

Please enter details of applicant if different from Section 1

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Title**  **(Mr, Mrs, Ms, Dr)** |  |
| **Forename(s)** |  | **Address** |  |
| **Telephone number** |  | **Postcode** |  |

**Declaration**

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the GDPR.

Please tick:

 I am the patient

 I have been asked to act by the patient and attach the patient’s written authorisation

 I have full parental responsibility for the patient and the patient is under the age of 18 and:

1. has consented to my making this request, or
2. is incapable of understanding the request (delete as appropriate)

 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)

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

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section 4: Proof of identity**

Please indicate how proof of ID has been confirmed. Please select ‘A’ or ‘B’:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Method in which identity is**  **confirmed** | **Option taken** | **Documents attached** |
| A | Attached copies of documents as  noted in section 4A below | Yes/No | If Yes, please indicate here which documents have been attached |
| B | Countersignature (section 4B). **This should only be completed in exceptional circumstances (e.g. in cases where the above cannot be provided)** | Yes/No | Please indicate reason why this section was completed |

**4A – Evidence**

**Evidence of the patient’s and/or the patient’s representative identity will be required. Please attach copies of the required documentation to this application form. Examples of required documentation are:**

|  |  |  |
| --- | --- | --- |
|  | **Type of applicant** | **Type of documentation** |
| **A** | An individual applying for his/her  own records | One copy of identity required,  e.g. copy of birth certificate, passport, driving licence, plus one copy of a utility bill or medical card, etc. |
| **B** | Someone applying on behalf of an  individual (Representative) | One item showing proof of the patient’s identity and one item showing proof of the  representative’s identity (see examples in ‘**A’** above) |
| **C** | Person with parental responsibility  applying on behalf of a child | Copy of birth certificate of child & copy of correspondence addressed to person with parental responsibility relating to the patient |
| **D** | Power of Attorney/Agent applying on behalf of an individual | Copy of a court order authorising Power of Attorney/Agent plus proof of the patient’s identity (see examples in ‘**A’** above) |

**4B – Countersignature**

**This section is to be completed by someone (other than a member of your family) who can vouch for your identity. This section may be completed if 4A cannot be fulfilled.**

I (insert full name).................................................................................................................

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

Has been known to me personally as .......................................... for ..........................years

(Insert in what capacity, e.g. employee, client, patient, relative etc.)

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 ................................................................................................................................

...............................................................................................................................................

Daytime telephone number .................................................................................................

**Additional notes**

Before returning this form, please ensure that you have:

1. Signed and dated this form

b) Enclosed proof of your identity or alternatively confirmed your identity by a countersignature

c) Enclosed documentation to support your request (if applying for another person’s records)

Incomplete applications, including any with lack of ID will be returned; therefore please ensure you have the correct documentation before returning the form. **EMAIL this completed form to: hepplewhiteandvirmani.noreply@nhs.net**