

Access to Health Records Department

Records Services

Calderdale Royal Hospital

Salterhebble Hill

Halifax

HX3 0PW

 Tel: 01422 222065

 Email:accesstodata@cht.nhs.uk

 Date:

Dear Sir/ Madam

Further to your recent enquiry to inspect/receive copies of your/ or on behalf of someone else (With authorisation/Legal Proof) hospital medical records. I would be grateful if you would complete and return the attached form together with all supporting documentation and proof of id and address in Section Four, listed within Group A, B, C or D.

The purpose of this form is to help us to identify the records you wish to access. It also allows us to preserve patient confidentiality by ensuring that hospital records are divulged only to the appropriate applicant. In certain circumstances we may wish to contact the witness who has certified your application as legitimate.

Please note, if you require fertility records, we will require both patient’s details and signatures on the form together with proof of id and address for both patients listed within Section Four, Group A and B

Under the UK General Data Protection Regulation/Data Protection Act 2018 there is no charge payable for this service to access medical records.

Copies will be supplied by an encrypted web link via e-mail Passwords will be sent out, by letter, separately in the post**.**

**Please keep this letter in a safe place as the password will be needed to open the encrypted link sent at the end of the process.**

**PLEASE NOTE** x-rays images/scans are not routinely provided, reports only will be supplied. If the images themselves are required these would be via an encrypted Web link and need to be specifically requested on the Subject Access Request Form in Section Three, (Details of information requested).

If you need any further help or information, please contact the Access to Health Records Office at the above address or telephone number.

Access to Health Records Team

Records Services



**Application Form for Access to Health Records**

 ***(UK General Data Protection Regulation and Data Protection Act 2018 & Access to Health Records Act 1990)***

**SECTION ONE - Details of the patient who is the subject of this application**

|  |  |
| --- | --- |
| Surname | First Name |
| Sex | Date of Birth |
| Address | Telephone Number |
| e-mail address Copies will be sent via encrypted web link **unless** otherwise specified.**Proof of address will be required as listed within Section Four Group A and B** |
| Post Code | NHS Number/ Hospital number (if Known) |

If the patient’s name and /or address differ from the above during the period(s) to which the application relates please give previous details

|  |  |
| --- | --- |
| Previous Surname | Previous First Name(s) |
| Previous Address |

**SECTION TWO - Details of Applicant if NOT the Patient**

Please complete this section if you are not the patient identified in Section One.

We need to know what gives you the authority to act on their behalf, so please state your relationship with them, for example, parent, solicitor, holder of power of attorney or deceased patient legal representative.

Please also check in Section Three for documentary evidence required to support your application.

|  |  |
| --- | --- |
| Surname | First Name(s) |
| Relationship to patient | Telephone Number |
| Address | e-mail address Copies will be sent via encrypted web link **unless** otherwise specified.**Proof of address and rights of access will be required as listed within Section Four Groups A, B, C and D.** |

|  |
| --- |
| **SECTION THREE - Details of Information Requested** In order for us to identify exactly what information to provide from the health records it would be helpful if you could complete the table below in as much detail as possible to identify the period(s)/episode(s) of care that you wish to obtain information about. If images themselves are required, please also make this clear below.Patient Hospital Number (If known) .....................................  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Dates of treatment****(From-To)** | **Hospital Attended** | **Ward/Department/** **Speciality or any Specific information to help with processing the request i.e Images required** | **Consultant** **(If Known)** | **Nature of illness/ accident** | **Any Further Supporting Information**  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**PLEASE COMPLETE AND SIGN ALL DECLARATIONS BELOW**

**DECLARATION BY APPLICANT**

I declare that the information given by me is correct to the best of my knowledge, and that I am applying for access to the patient health records identified above under the UK General Data Protection Regulation/Data Protection Act 2018 or the Access to Health Records Act 1990 in the following capacity:

* I am the patient.

(See below in Section Four, *Supporting documentation necessary for application)*

* I have been asked to act by the patient. I enclose the patient’s written authorisation.

**(Complete the authorisation below in Section Six or attach separate written authorisation from the patient.)**

(See below in Section Four, *Supporting documentation necessary for application)*

* I am the parent, or I am acting *in loco parentis* of the patient and/or exercise parental responsibility for the patient, who is under 13 and is either incapable of understanding this request or has consented to my application.

(See below in Section Four, *Supporting documentation necessary for application)*

* I have been appointed by the court to manage the affairs of a patient deemed

to be incapable and I hold a Lasting Power of Attorney for Health and Welfare of this patient and I enclose a copy of the authority (See below in Section Four, *Supporting documentation necessary for application)*

* I am the deceased patient’s personal representative / legal executor (the executor or administrator of the deceased person's estate) and hold and enclose legal proof of my appointment.

*Please note you are only entitled to copies of those records that will assist you in carrying out your duties on behalf of the Estate.*

 (**I have** **attached confirmation documentation of my appointment).**

(See below in Section Four, *Supporting documentation necessary for application)*

* I have a claim resulting from the patient’s death(Only information directly relevant to a claim will be disclosed) on the grounds of (The application will not be processed without this Information) ……………………………………………………………………...

(**I have** **attached confirmation/information documentation)**

(See below in Section Four, *Supporting documentation necessary for application)*

**SECTION FOUR - Supporting documentation necessary for application**

**Please do not send any original documents. You can send printed copies or electronic copies. (The following list is not exhaustive).**

**Applying for yourself**

If you are applying for yourself, we need to see:

* One document confirming your name, from Group A, below
* One document confirming your address, from Group B, below

**Applying on behalf of someone else (living patient)**

If you are applying on behalf of someone else, we need to see:

* One document confirming your name, from Group A, below
* One document confirming the name of the person you are applying on behalf of, from Group A, below
* One document confirming your address, from Group B, below
* One document confirming the address of the person you are applying on behalf of from Group B, below
* All documents needed to show that you have the authority to access the records, from Group C, below.

**Applying on behalf of someone else as a deceased patient’s personal representative or have a claim arising from the patient’s death**

If you are applying on behalf of someone else, as a deceased patient’s personal representative/have a claim arising from the patient’s death we need to see:

* One document confirming your name, from Group A, below
* One document confirming your address, from Group B, below
* All documents needed to show that you have the authority to access the records, from Group D, below.
1. Documents that confirm your name:
* Full driving licence
* Passport
* Birth certificate
* Marriage or civil partnership certificate

B. Documents that confirm your address (dated within the last 3 months):

* Utility bill
* Bank statement
* Credit card statement
* Benefit book
* Pension book

C. Documents that confirm you are allowed to act on behalf of the person you are making the request for:

* Health and Welfare Lasting Power of Attorney
* Court of Protection Order appointing you as a personal deputy for the personal welfare of the Subject
* Full birth certificate of child
* Full certificate of adoption
* Parental responsibility order
* Signed declaration from the subject

D.

* Copy of a Will
* Certificate of probate,
* Official letter from a solicitor stating my legal right to access this information
* Confirmation/information supporting the grounds of the claim are………………........................................................................................................................................................................................................................................

**SECTION FIVE - Patient Applicant**

I am the patient whose details appear in Section One

**Applicant Signature**........................................................................**Date**.........................................

**SECTION SIX - Patient Authorisation to Grant access to a Nominated Representative**

I am the patient whose details appears in Section One and give authorisation for the applicant whose details appear in Section Two to be provided with access to my Health Records covering the periods and episodes of care detailed in Section Three

**Signed**........................................................................ **Date**...................................

**SECTION SEVEN - To be completed by a responsible adult who knows the applicant**

Witness Certification: -

I certify that I (print name) ........................................................................................................

Of (address)

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

have known the applicant for .........years as an employee/client/patient/friend and have witnessed the applicant sign this form.

**Signed**........................................................................ **Date**........................................

I would like \*copies of the Records

I would like to view the original Records

*(delete as required)*

**\***Copies will be sent via encrypted web link unless otherwise specified.

**Passwords will be sent out in the post separately upon receipt of your completed application and all supporting documentation.**

**Please return the completed form together with all supporting documentation to:**

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