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**Application for Access to Health Records**

**under The EU General Data Protection Regulation (GDPR), Data Protection Act (DPA) 2018 and Health Records Act 1990**

 *(Please complete this form in black ink and block capitals)*

* + 1. **Details of the patient about whom the information is requested**

|  |  |
| --- | --- |
| Surname: | Forename(s): |
| Date of Birth: | Hospital Number, if known: |
| Address: |
| Phone number: | Email address(optional): |

**What is being applied for (tick as applicable).**

|  |  |
| --- | --- |
| I am applying to view my health records |  |
| I am applying for copies of my health record |  |

**Please tick the box below identifying whether you or a representative on your behalf is applying for access.**

|  |  |
| --- | --- |
| I am applying to access my health records |  |
| I have instructed my authorised representative to apply on my behalf |  |

* + 1. **Details of Applicant if you are not the patient**

(Please complete this section onlyif you are requesting notes on behalf of the patient, ie you are the patient’s nominated representative or next of kin).

|  |  |
| --- | --- |
| Surname: | Forename(s): |
| Your relationship to the patient: | Hospital Number, if known: |
| Address: |
| Phone number: | Email address(optional): |
| If the patient is deceased, please state your legal entitlement under the Access to Health Records Act 1990: |

**Signature of applicant ……………………………………..**

**Print name ……………………………………………………**

**Date ……………………………………………………………**

* + 1. **Records Required:**

Please tick the appropriate boxes:

All Hospital Records

Or Specific Records:

Urgent Care Centre attendance

Outpatient Department attendance

St John’s Hospice Health Record

Xrays/Images provided by the Imaging Department on disc

Imaging Reports

Blood Results

Other – please specify…………………………………………………………………………….

**Please note we do not photocopy the notes of current inpatients. Should you wish to view your records whilst in as an inpatient please discuss this with your Care Team.**

* + 1. **Declaration**

I declare that the information given on this form is correct to the best of my knowledge

I am the Patient

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

I have parental responsibility and the patient is under 16 and has consented to my making the request and I have attached the child’s written authorisation or they are under 12 or have no capacity to understand (delete, as appropriate).

I am the deceased patient’s personal representative and attach confirmation of this as I am the:

1. Executor of the will – a copy of the will or solicitor confirmation is required
2. Personal representative – a letter of authority from a solicitor or government body is required
3. Have a personal claim – a formal letter from a solicitor or a patient group is required

For solicitors only – I have a claim arising from the patient’s death and wish to access information relevant to my claim on the grounds that:

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

**Name of Requester ………………………………………………………………………………………………**

**Signature of Requester…………………………………………………………………………………**

**Date………………………………**

* + 1. **Identity Checks**

Patients or their representative may be required to provide one form of photographic identity and/or one proof of address. Examples to use are:

Photographic Identity**:**

1. Driving Licence (if a UK licence it can also be used as proof of address)
2. Passport
3. HM Forces ID card

If an original from the list above cannot be provided then a certified copy is acceptable.

Proof of Address:

1. Utility bill within last 3 months
2. Bank statement
3. P45, P60 or benefit document
4. Council Tax bill for current year

Originals must be provided from the list above.

NB All documents will be returned.

Please send this form, along with the necessary identification, to the following address:

PA to the Chief Nursing Officer,

Hospital of St John & St Elizabeth,

60 Grove End Road,

St John's Wood,

London

NW8 9NH

**For office use only:**

**Date application received…………………………………..**

**Received by…………………………………………………...**

**Signature………………………………………………………**

**Date ………………………………………………………….....**

**Entered on SAR secure spreadsheet by………………....**

**Proof of identity received……………………………………**

**Proof of address received…………………………………...**

**Signature………………………………………………………**

**Date ………………………………………………………….....**