Great Western Hospitals NHS
NHS Foundation Trust

In Confidence

APPLICATION FOR ACCESS TO HEALTH RECORDS
(Data Protection Act 1998/ Access to Health Records Act 1990)

A fee will be made for providing copies of health records. (See our Patient Information sheet for more details)

1. RECORD TYPE (please tick):

How do you require access to be provided? **PHOTOCOPIES** ☐ **VIEW ONLY** ☐

Type of health records required: **HEALTH RECORDS** ☐ **X-RAYS** ☐ **PHOTOGRAPHS** ☐

PHYSIO RECORDS ☐ **COMMUNITY TEAM RECORDS** ☐ **OCCUPATIONAL HEALTH RECORDS (staff) (complete sections 2, 4 & 5 only)** ☐

2. PARTICULARS OF PERSON WHOSE INFORMATION IS REQUIRED:

Surname:	Forename(s):	
Current Address:		
Email Address:		
Tel No:	Date of Birth:	Date of Death:
Hospital No. (if known):	NHS Number (if known):	
Employment Dates: (for OH requests only)		

If the name and/or address of the patient were different from the above during the period(s) to which your application relates, please give details:

Previous Name:	Previous Address:

3. HOSPITAL DETAILS:
(Please provide as much information as possible)

Hospital e.g. GWH, Savernake, Trowbridge, Chippenham, Warminster, Melksham,	**Dates of attendance**	**Type of Records** e.g. Inpatient, Outpatient, A&E, MIU, Physiotherapy, Maternity, Children's, Community Teams	**Name of Health Professional (if known)** e.g. consultant, doctor, nurse, therapist

4. DECLARATION:

I declare that the information given by me is correct to the best of my knowledge and that:

* I am the patient

* I am acting on behalf of the patient and attach proof (such as power of attorney or letter of authorisation)

* I am the parent or acting in loco parentis and the patient is under 16 years of age

* I am the deceased patient's representative and attach confirmation of my appointment

* I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that:

....

(* delete as appropriate)

Signed:...

Date:..………

If you are not the patient please complete the box below:

Your name:……………………..……………………..……… Your relationship to the patient:…………………………..……………

Your address:………..…....

Your contact telephone number:……………………………………………………………………….……………………..

Your Email Address: ………………………………………………………………………………………………………

5. AUTHORISATION: (where appropriate)

Part 1 (on behalf of another person)

I hereby authorise Great Western Hospitals NHS Foundation Trust to release information from my health records to:

...............................………….. to whom I have given my consent to act on my behalf.

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

Part 2 (in the case of a person under the age of 16, a responsible adult should certify, where appropriate, that the child understands the nature of the application)

I (name)..…………………………………….......

of (address) ……...

certify that the applicant understands the nature of this application.

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

Please return the completed form to:

Health Records Supervisor (Support Services)
Great Western Hospital
Marlborough Road
Swindon
SN3 6BB

Any fee will be notified to you and will be payable prior to collection or dispatch. Please note posted items will be subject to an additional special delivery charge. Cheques should be made payable to Great Western Hospitals NHS Foundation Trust.