Great Western Hospitals NHS Foundation Trust

IN CONFIDENCE

APPLICATION FOR ACCESS TO HEALTH RECORDS
(Data Protection Act 2018/Access to Health Records Act 1990)

1. PARTICULARS OF PERSON WHOSE INFORMATION IS REQUIRED:	
Surname:	Previous Name (if applicable):
Forename/s:	Date of Birth:
Current Address:	Previous Address (if this will be on our records):
Email Address:	
Phone / Mobile No:	Date of Death (if applicable):
Hospital No. (if known):	NHS Number (if known):
Employment Dates: (for Occupational Health requests only)	

2. METHOD OF ACCESS (please tick):			
Copies	☐	**View Only**	☐

Your medical records folder will contain a large number of different types of information such as clinical notes written by healthcare professionals at the time of your appointment, correspondence and investigations. In order to reduce the amount and cost of photocopying, it would be helpful if you could indicate which sections of the medical records you require copies of and whether this relates to all treatment received or to a specific period. Please note that in accordance with the provisions of the Data Protection Act 2018 the Trust reserves the right to charge for production of records where the request is excessive.

- ☐ Clinical notes (notes taken by your doctor at your appointment/in-patient stay)
- ☐ Correspondence
- ☐ Temperature and other observational charges (such as fluid charts)
- ☐ Nursing notes (completed by nursing staff on the ward regarding your day to day treatment)
- ☐ Investigations (blood tests, urine tests, etc.)

3. RECORD DETAILS:

Date or year of attendance	**Specific service, location, ward, speciality, or department (if known)**	**Name of Health Professional (if known)** *e.g. consultant, doctor, nurse, therapist*

If you would like x-rays/scans included please confirm either:	Written Report:	☐	Copy on CD:	☐	

Please confirm if you would like records from any of these areas:	A&E (ED):	☐	Audiology:	☐	Maternity:	☐

4. DECLARATION:

I declare that the information given by me is correct to the best of my knowledge and that (please tick relevant box):

☐ 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 as 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:

Signed: Date:

If you are not the person whose information is required please complete the box below:

Your name: Your relationship to the patient:

Your address:

Your Phone no: 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 consent to act on my behalf.

Signature: Name: 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: Name: Date:

Please post the completed form to: **Health Records Supervisor (Support Services)**
Great Western Hospital, Marlborough Road, Swindon SN3 6BB

or email to: **gwh.subjectaccess.requests@nhs.net**

We will endeavour to provide you with the information you have requested **within one calendar month** of the date of receipt of your request. We will contact you before this if we have any queries or are unable to locate the records you have requested.