NHS
Great Western Hospitals
NHS Foundation Trust

| APPLICATION FOR ACCESS TO HEALTH RECORDS | |
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| Please provide as much information as possible which may be of assistance to the Trust in processing your request. Incomplete forms will be returned which may delay the processing of your request.<br>**To process your request, the Trust will require two types of Identification from the applicant. (person requesting the information). The last page of this form includes guidelines about the types of identification which are acceptable.** | |
| **Section 1. Personal Details of Patient** | |
| Last Name: | Forename: |
| Any previous name (s): | Date of Birth: (dd/mm/yyyy) |
| NHS and/or Hospital number (if known): | |
| Contact Telephone number: | Email address: |
| Current Address: (inc. postcode) | |
| Previous Address: (if this will be on the Trust's records) | |
| Last name and forename of applicant if different from the patient: | Postal address to which the response should be sent (if different from that of the patient): |
| Email address of applicant: | |
| **Section 2: Identification** | |
| To process your request, copies of two types of identification will be required from the applicant<br>If you are applying for access to health records on behalf of a patient, proof of this will be required.<br>Details of the type proof and ID which will be accepted can be found at end of this form. | |

| Section 3a – Details of the patient record that is being requested | | | | | | | |
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| **Please tick which records you are requesting from the following areas:** | | | | | | | |
| A&E (ED): | ☐ | Audiology: | ☐ | Maternity: | ☐ | Radiology (images): | ☐ |
| Inpatients: | ☐ | Outpatients: | ☐ | Physiotherapy: | ☐ | | |

**Please provide details of the hospital episode(s)/part(s) of the health record you require copies of using the table below:**

| **Date of attendance:** | **Specific service location, ward, speciality or department if known:** |
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| Section 3b: Viewing your Records | |
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| If you wish to view your records only, please tick this box. You will then be contacted to make an appointment to visit the hospital to view the records. | ☐ |

| Section 3c: Requesting Radiology Images | |
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| If you have requested copies of any imaging performed at the Great Western Hospital, this will be sent to you electronically using a system called IEP (Image Exchange Portal).<br><br>To do this, we require an email address and a UK mobile phone number.<br>A link to access your images will be sent to the email address provided below and a password to access these images will be sent with an SMS message to the UK mobile phone number. If you do not have a UK mobile phone number, we can send the password to a secondary email address.<br>Please be aware that if you have requested copies of your health records in addition to Radiology images, the copies of your records will be sent separately. | |
| **Email Address:** | |
| UK mobile phone number **or secondary Email address:** | |

## Section 4: Declaration

I declare that the information I have given 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 Data Protection Act (2018) and/or Access to Health Records Act (1990)

Please tick **one** of the following boxes:

| | |
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| I am the patient: (complete section 5) ☐ | I have parental responsibility/legal guardianship for the patient (who is a child under 16 years of age: (complete section 6) ☐ |
| I have been asked to act on behalf of the patient: (complete section 7) ☐ | I have been appointed the Guardian for the patient, under a Guardianship order: (complete section 7) ☐ |
| **Access to Records of the Deceased:**<br>I am the deceased patient's personal representative and attach confirmation of my appointment: (complete section 5) ☐ | **Access to Records of the Deceased:**<br>I have a claim arising from the patient's death and wish to access information relevant to my claim. Please provide additional information below: (complete section 5) ☐ |

**Access to Records of the Deceased:** Please provide additional information (if necessary to support your application):

## Section 5 – Authorisation

I declare that the information given by me is correct to the best of my knowledge. **I have enclosed two forms of identification.**

Applicant's signature: ……..

Date: (dd/mm/yyyy: …….

## Section 6: Authorisation to be completed by a parent/legal guardian acting on behalf of a child under 16 years of age:

Signature: ……..

Date: (dd/mm/yyyy) ……

| **Section 7: Authorisation (to be completed only when the applicant is acting on behalf of another adult patient)** |
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| I……. (print name) consent to Great Western Hospitals, NHS Foundation Trust releasing any health records it may hold relating to me (as described above) to…… (insert name of person acting on your behalf) to whom I have given consent to act on my behalf).<br><br>Signature: ……..<br><br>Date: (dd/mm/yyyy) …… |
| **Section 8 – Authorisation to be completed by patient's personal representative** |
| I declare that the information given by me is correct to the best of my knowledge. **I have enclosed proof that I am authorised to act on behalf of the deceased patient and two forms of identification.**<br><br>Applicant's full name: ……<br><br>Applicant's signature: ……..<br><br>Date: (dd/mm/yyyy: ……. |

**Completed forms:** should be sent to:

Email with attachments to: gwh.subjectaccess.requests@nhs.net

Or by post to: Medical Records Department, Subject Access Team, Great Western Hospitals NHS Foundation Trust, Marlborough Road, SWINDON, SN3 6BB.

**Examples of Proof of Entitlement to Access Health Records and Proof of ID**

| Applicant | Typical Minimum Proof |
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| Patient | • Copy of passport, driving licence or birth certificate, and<br>• A photocopy of a utility bill dated within the last 3 months |
| Patient's Representative (e.g. relative, carer or attorney) | **One of the following:**<br>• Copy of Lasting Power of Attorney (LPA)<br>• Evidence of appointment as Independent Mental Capacity Advocate (IMCA)<br>**and**:<br>• Two proofs of identity from patient's representative |
| Person with parental responsibility for a child patient | **One of the following**:<br>• Parent's name on child's birth certificate, or<br>• Proof of legal guardianship<br>**and**:<br>• Two proofs of identity from the patient's parent / legal guardian |
| Stepparent married to biological parent of child patient | • Marriage certificate<br>• Birth certificate of child<br>• Final adoption papers from Court, or<br>• Written agreement from child's biological parent, submitted to court<br>**and**:<br>• Two proofs of identity from the stepparent |
| Unmarried biological parent of child patient | • Parent's name on the child's birth certificate<br>• Court order granting parental responsibility<br>• Copy of a parental responsibility agreement signed by both parents<br>**and:**<br>• Two proofs of identity from the patient's parent |
| Personal Representative of deceased patient (i.e. executor or administrator of estate) | **One of the following:**<br>• Copy of the deceased's will<br>• Copy of Probate<br>• Copy of Lasting Power of Attorney (if still valid at the time of death)<br>**and**:<br>• Two proofs of identity of the personal representative |
| Person who may have a claim arising from the patient's death | • Evidence supporting claim<br>• Two proofs of identity from the applicant |
| Person requesting copies of deceased patient's records who does not fall into either of the above two categories | • Two proofs of identity from the applicant<br>• Evidence of relationship to the deceased patient<br>• Reason for making the request |