NHS
East Suffolk and North Essex
NHS Foundation Trust

Application for Access to Diagnostic Images

(In accordance with the Data Protection Act 2018 and Access to Health Records Act 1990)

Please complete this form in BLOCK CAPITALS and return to the address overleaf.

When the completed form is received by Medical Imaging a strict process is undertaken. You should receive a response from us within **a calendar month** of receiving your application and identification.

Section 1 – The individual the information relates to

Title: ..... Surname: .....

Forename(s): .....

Date of birth: ..... / ..... / ..... Hospital no/NHS no (if known): .....

Email address: ..... Telephone no(s): .....

Home address: .....

..... Postcode: .....

If the above has been known by a different name or has lived at a different address during the period to which the information relates, please give details below:

Name: .....

From [date]: ..... / ..... / ..... To [date]: ..... / ..... / .....

Home address: .....

..... Postcode: .....

Identification

I enclose a copy of one of the following as proof of the identify of the individual above:

☐ Birth certificate ☐ Driving licence ☐ Passport

Section 2 – Is the requested information about you?

No, the information is not about me ➔ go to section 3.

Yes, the information is about me ➔ go to section 4.

Section 3 – Details of the person making the request if NOT the patient

☐ I have been asked by the patient and attach his/her written consent and a copy of my identification.

☐ I am acting in *loco parentis* as the patient is under the age of 16 and attach a copy of my identification.

Title: ..... Surname: .....

Forename(s): .....

Email address: ..... Telephone no(s): .....

Home address: .....

..... Postcode: .....

Section 4 – What information are you requesting?

☐ Copy of image only ☐ Copy of report only ☐ Copy of images and report

Information requested covers the dates from: ..... / ..... / ..... To: ..... / ..... / .....

Any further information: .....

.....

Section 5 – Access to Information

Please indicate the format you require the above information to be sent via:

☐ Email – please ensure both email address and mobile phone number are completed overleaf
☐ Disc via Royal Mail Signed for Post

Declaration and Authorisation

I declare that the information I have completed on this form is correct to the best of my knowledge and that: *(*please delete below as appropriate)*

- *I am the person named overleaf in Section 1. (***Please complete Section 1 below.***)
- *I am acting on behalf of the person named overleaf in Section 1. (***Please complete Sections 1 AND 2 below.***)

Section 1

I, (***insert full name in BLOCK CAPITALS***) ....., certify that I am the person named overleaf, declare the information given by me is correct to the best of my knowledge and that I am entitled to apply under the Data Protection Act 2018 for access to personal data that the Trust holds about me. I understand that it is necessary for Ipswich Hospital to confirm my identity and/or locate the correct information.

AND

I give my consent for the for the person named below to make a Subject Access Request (SAR) on my behalf under the Data Protection Act 2018 to Ipswich Hospital. I am aware that it is an offence to unlawfully obtain such information. I certify that the information given in this form is true.

Signed: ..... Date: ..... / ..... / .....

Section 2 *(If you are acting on behalf of the person named overleaf, you also need to complete Section 1.)*

I, (***insert full name in BLOCK CAPITALS***) ....., have consent from the person named in Section 1 to act on their behalf and attach a copy of their consent.

Signed: ..... Date: ..... / ..... / .....

Please return this form to: Directorate Administrator, Medical Imaging (C355) Ipswich Hospital, Heath Road, Ipswich, IP4 5PD or email it to **ihn-tr.imagingsar@nhs.net**

Office Procedures

Request received by: ..... Location: ..... Date: ..... / ..... / .....

Written consent correct? Yes ☐ No ☐ **Proof of identification attached?** Yes ☐ No ☐

CD burnt: ☐ By: ..... Date: ..... / ..... / .....

CD delivery: Collected/Taken by patient ☐ **(Ask patient to sign below.)**

To be sent ☐ Date sent: ..... / ..... / ..... Registered Delivery barcode:

Receipt of Copy Images

I acknowledge safe receipt of my copy X-ray disc as requested and understand that it is my responsibility to ensure safe storage and carriage of this information which contains personal identifiable information about me or the person I am representing.

Signed: ..... Date: ..... / ..... / .....