**Application for Access to Health Records**

**(Colchester Hospital)**

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

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

When the completed application form is received by the Access to Health Records Team, a strict process in undertaken. You should receive a response from us within one calendar month of receiving your request.

**Section 1 - The individual the information required relates to:**

|  |
| --- |
| Surname: ………………………….............. Forenames: ……………………………………… Current address: ……………………………………………………………………..……… Postcode: ..……………………… Date of Birth: …………………............................ Hospital/NHS No: ….……………....................... Telephone Number: ….…………………………. Mobile Number: ………………………………….  |

Surname: ………………………….............. Forenames: ………………………………………

Current address: ……………………………………………………………………..………………

………………………………………......…… Post Code: ..………………………

Date of birth: …………………............................

Hospital/NHS no.: ……………….......................

Telephone Number: …………………………….

Mobile Number: ………………………………….

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

Birth certificate □

Driving licence □

Passport □

If none of these documents are available please contact the Data Protection Officer for advice on other acceptable forms of identification.

**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)

**Please note: If information to be disclosed includes incidental disclosure of third party (for example family member, referee, care worker) it cannot be disclosed without the consent of that party.**

**Section 3 - The person acting on behalf of the individual:**

|  |
| --- |
| Surname: ………………………….............. Forenames: ……………………….…………… Current address: ………………………………………………………………………………… Postcode: ..……………………… Date of Birth: …………………............................ Hospital/NHS No: ………………....................... Telephone Number: …..…………………………. Mobile Number: ……….…………………………. |

What is your relationship to the data subject? (for example, parent, carer, legal representative) ……………………………………………………………………………………

Do you have legal authority to request the data subject’s personal information?

Yes □

No □

If the data subject is under 16 years old, do you have parental responsibility for them?

Yes □

No □

Please provide proof that you are legally authorised to act on the data subject’s behalf in the form of:

Evidence of parental responsibility □

Letter of authority □

Lasting Power of Attorney □

Explicit Patient Consent □

Other (give details) □

Please provide proof that you are the person authorised to act on behalf of the data subject by enclosing a copy of one of the following:

Birth certificate □

Driving licence □

Passport □

**If none of these are available, please contact the Data Protection Officer for advice on other acceptable forms of identification.**

**Section 4 – What is the nature of the request you are making?**

Please help us deal with your request quickly and efficiently by giving as much detail as possible about the information you want. If possible restrict your request to a particular council service or department, period of time or incident.

**Information requested in more detail: (please use a separate sheet of paper if required)**

**Information requested covers (dates):**

From: To:

Relevant details to help us locate the information (for example address at the time, service or department, names of previous contacts, any file reference if known)

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**Any other comments**:

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………

**Section 5 - Access to the information**

**Please circle which format you require paper records to be sent via:**

 **Email Paper**

**Radiology can only be emailed, so please ensure you have supplied either 2 email addresses or 1 email address and 1 UK mobile number.**

**Please supply an email address to receive electronically:**

……………………………………………………………………………………………………………

**Please supply a postal address if different to the patient’s:**

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**Section 6 - Declaration and authorisation:**

**Warning – a person who unlawfully obtains or attempts to obtain personal information is guilty of a criminal offence and is liable to prosecution.**

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

\* I am the person named in Section 1 (please sign Signature 1 below)

\* I am acting on behalf of the person named in Section 1 (please sign Signature 2 below)

\* I am the Legal Representative – for information relating to deceased patients only

(please sign Signature 3 below)

**Signature 1** (if you are the person named in section 1 of this form)

I (insert full name in BLOCK capitals) …………………………………………………………….

certify that I am the person named overleaf.

Signed: ……………………………………………….... Date: ……………………………………

**Signature 2** (if you are acting on behalf of the person named in section1 (details listed in Section 3) i.e., Parent/Guardian or Legal Representative). Please ensure you supply a copy of the child’s full birth certificate or Power of Attorney where applicable.

I (insert full name in BLOCK capitals) …………………………………..…………………………

Signed: …………………………………………………. Date: ……………………………………

**Signature 3** (if you are the legal representative – for information relating to deceased patients only). Please ensure you provide a copy of the legal evidence such as the patient’s Will or Letters of Administration.

I (insert full name in BLOCK capitals) …………………………………………………………….

certify that I am the Legal Representative to the person named in Section 1.

Signed: …………………………………………………. Date: .……….…………………………

**Please check that you have completed all fields of the form and all details are correct.**

Please return this completed form, along with accompanying documents of the relevant identification/certification to:

Access to Health Records Department

Health Records Centre

Colchester General Hospital

Turner Road

Colchester

Essex

CO4 5JL

Tel: 01206

Email CHU-FTR.HEALTHRECORDS@NHS.NET (preferred)

**This form will be kept for a minimum of 3 years by the Access to Health Records team. It will then be confidentially destroyed. This follows the National Guidance Records Management NHS Code of Practice Retention Schedule 2016**