East Suffolk and North Essex
NHS Foundation Trust

Application for Access to Health Records (Ipswich Hospital)

(In accordance with the General Data Protection Regulations (EU) 2016/679/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 relates to:

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 is 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: ……..……

……..…… Post Code: ..……

Date of birth: ……......

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, 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 enclose a copy of one of the following:

Birth certificate □ Driving licence □ Passport □

If none of these is 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)

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Any other comments:

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Section 5- Access to the information

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

Email **Paper**

Please contact the Radiology Team for Discs- Discs must be sent via Royal Mail Signed For post.

Please supply email address to receive electronically:

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

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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 completed 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 complete 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) ie, Parent/Guardian or Legal Representative.

I (insert full name in BLOCK capitals) ……

Signed: …… Date: …….

Signature 3 (if you are the legal representative – for information relating to deceased patients only)

I (insert full name in BLOCK capitals) ……
certify that I am the next of kin 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 Dept.

Ipswich Hospital, Heath Road, Ipswich, Suffolk, IP4 5PD

Tel: 01473 712 233 **Email – ihn-tr.healthrecords-access@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