

## APPLICATION FOR COPIES OF HEALTH RECORDS

### NOTES FOR APPLICANTS

**Ensure you read these guidance notes before completing the Application Form**

**An incomplete form or a failure to provide the required identify / legal documents will result in the application not being processed or being delayed**

#### Charges for processing your application

The Data Protection Act 1998 allows for a charge to be applied for this service up to a maximum of £50.00.

Requests relating to **deceased patient's records** are governed by the Access to Health Records Act 1990 there is no maximum limit to the charge in these cases.

All charges include postage by recorded delivery and where applicable:

- A £10.00 administration fee unless you have been seen within the last forty days of the application in which case this fee does not apply.
- Paper records at a charge of 30p per page (single sided, A4).
- Most records are available in an electronic format and will be provided on an encrypted CD. The charge for records in this format is £10.00.
- If copy radiology (x-rays) is required this information will be provided on an encrypted CD. The charge for x-rays is £10.00.

Once the copy information is available you will be notified of the charge. Payment is required before the information is disclosed.

Cheques/Postal Orders should be made payable to:

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Please note we do not have the facilities to accept payment by credit or debit card.

#### Note 1 (Part A) – Identity of the person about whom the information is requested

*This part must be completed for all applicants.*

Complete all details relating to the patient whose records you wish to access. This should include former names (e.g. maiden name) and previous address, if applicable, for the period relating to the record requested.

If known please provide the Hospital Registration Number and NHS Number.

#### Note 2 (Part B) – Details of the information required

*This part must be completed for all applicants.*

You must specify the records you wish to access and provide as many details as possible. If there is insufficient space, please attach a continuation sheet.

Example

Consultant or Department	Condition/Illness	Approximate Date
Mr Smith	Broken Leg	March 2007
Physiotherapy	Back pain	June 2008
ECG	Chest Pain	November 2009

Note 3 (Part C) – Declaration

*This part must be completed by the person seeking access.*

A photocopy of a document (e.g. passport, birth certificate) that will support the identification of the Applicant must be attached to the completed Application Form.

Tick one box only which best describes you.

Sign and date in the space provided, and if you are not the patient, provide your address, telephone number and relationship to the patient.

Note 4 (Part D) – Authorisation for Application made on behalf of patient

This part should only be completed when the applicant is not the patient but has been authorised by the patient to make the application.

Once the details in sections A to C have been completed the patient should sign and date in the space provided to officially authorise the applicant's request for access.

GENERAL NOTES

1. WARNING – It is a criminal offence to make false or misleading statements in order to obtain information.
2. Patients, including those who are deceased, have a right to confidentiality of their personal health information and the hospital must be satisfied that an applicant is the patient or the patient's authorised representative. This may involve checking the identity of any of the named persons on the completed application form and their validity to request access.
3. Information may be withheld where it is considered that access might cause harm to the physical or mental health of the patient or any other individual, or where a third party might be identified. It is not a requirement for the Trust to disclose the fact that information has been withheld.

PLEASE COMPLETE IN BLOCK CAPITALS

**APPLICATION FOR COPIES OF HEALTH RECORDS**

**Part A – Identity of the Person about whom the information is requested** (see note 1)

<b>SURNAME:</b>	<b>FORMERLY:</b>
<b>FORENAME(S):</b>	<b>DATE OF BIRTH:</b>
<b>CURRENT ADDRESS:</b>	<b>PREVIOUS ADDRESS:</b>
<b>TEL NO:</b>	<b>E-mail*:</b>
<b>HOSPITAL NUMBER:</b>	<b>NHS NUMBER:</b>

\*Please supply an e-mail address to receive an acknowledgement of receipt of your request and to enable us to keep you informed about progress with your application.

**Part B – Details of the information required** (see note 2)

Consultant or Department	Condition/Illness	Approximate Date

**X-Ray Images Required (CD)                      YES / NO**

**X-Ray Reports only                                      YES / NO**

**Part C – Declaration** (see note 3)

**I declare that the information given is correct to the best of my knowledge and that I am entitled to apply for access to the information detailed above.** (Tick as appropriate)

I am the patient named in Part A.

I have been authorised to act by the patient. (*Part D must be completed*)

The patient is under 18 years of age. I am the patient's parent/legal guardian and have parental responsibility.

The patient is over 16 years of age. I am their next-of-kin/legal representative. I am making this application as they lack the capacity of understanding to make the request. Please provide proof of evidence to support your application (e.g. Lasting Power of Attorney relating to health care)

I am the deceased patient's personal representative and attach conformation of this. If you are applying for the records of a deceased patient please provide Grant of Probate or Letters of Administration.

<b>SIGNED:</b>	<b>ADDRESS</b> (if different from that in Part A)
<b>PRINT NAME:</b>	
<b>DATE:</b>	
<b>TEL NO:</b>	
<b>RELATIONSHIP TO PATIENT:</b>	

**Part D – Authorisation for application made on behalf of patient** (see note 4)

**I hereby authorise release of my health records, as specified above, to the person named in Part C and declare that I am the patient named in Part A of this form.**

<b>SIGNED:</b>
<b>PRINT NAME:</b>
<b>DATE:</b>

**WARNING: It is a criminal offence to make false or misleading statements in order to obtain information.**

**PLEASE ENSURE YOU HAVE ATTACHED THE  
REQUIRED IDENTITY / LEGAL DOCUMENTS**

**WITHOUT THIS INFORMATION WE WILL BE UNABLE  
TO PROCESS YOUR REQUEST**

Please return the completed form to:

- Access to Records
- Legal Services Department
- Alexandra Hospital
- Woodrow Drive
- Redditch
- Worcestershire
- B98 7UB

Any queries regarding completion of this form please contact 01527 503850.