Wiltshire HEALTH AND CARE

NHS

IN CONFIDENCE

APPLICATION FOR ACCESS TO HEALTH RECORDS

(General Data Protection Regulation/ Access to Health Records Act 1990)

1. RECORD TYPE (please tick):

How do you require access to be provided? **PHOTOCOPIES** ☐ **VIEW ONLY** ☐

Type of health records required: **HEALTH RECORDS** ☐ **X-RAYS** ☐ **PHOTOGRAPHS** ☐

PHYSIO RECORDS ☐ **COMMUNITY TEAM RECORDS** ☐ **OCCUPATIONAL HEALTH RECORDS (staff) (complete sections 2, 4 & 5 only)** ☐

2. PARTICULARS OF PERSON WHOSE INFORMATION IS REQUIRED:

Surname:	Forename(s):	
Current Address:		
Email Address:		
Tel No:	Date of Birth:	Date of Death:
Hospital No. (if known):	NHS Number (if known):	

If the name and/or address of the patient were different from the above during the period(s) to which your application relates, please give details:

Previous Name:	Previous Address:

3. HOSPITAL DETAILS:

(Please provide as much information as possible)

Hospital e.g. Savernake, Trowbridge, Chippenham, Warminster, Devizes, Melksham	**Dates/Year of attendance**	**Type of Records** e.g. Inpatient, Outpatient, Minor Injury Unit, Physiotherapy, Podiatry, Community Teams (district nursing), Wheelchair, etc.	**Name of Health Professional (if known)** e.g. consultant, doctor, nurse, therapist

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4. DECLARATION:

I declare that the information given by me is correct to the best of my knowledge and that:

☐ I am the patient

☐ I am acting on behalf of the patient and attach proof (such as power of attorney or letter of authorisation)

☐ I am the parent or acting in loco parentis and the patient is under 16 years of age

☐ I am the deceased patient's representative and attach confirmation of my appointment

☐ I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that:

.....

(Please tick as appropriate)

Signed:.....

Date:.....……

If you are not the patient please complete the box below:

Your name:……..…….…… Your relationship to the patient:……..……

Your address:……..……..

Your contact telephone number:……..……..

Your email address: ……

5. AUTHORISATION: (where appropriate)

Part 1 (on behalf of another person)

I hereby authorise Great Western NHS Foundation Trust on behalf of Wiltshire Health and Care LLP to release information from my health records to:

..... to whom I have given my consent to act on my behalf.

Signature:…….. Date:……

Part 2 (in the case of a person under the age of 16, a responsible adult should certify, where appropriate, that the child understands the nature of the application)

I (name).....……..

of (address) ……...

certify that the applicant understands the nature of this application.

Signature: …… Date: ……..

Please return the completed form to:

Executive Assistant
Room 2047, Rowan West
Wiltshire Health and Care
Chippenham Community Hospital
Rowden Hill, Chippenham
SN15 2AJ