**IN CONFIDENCE**

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| **APPLICATION FOR ACCESS TO HEALTH RECORDS (patients or their representatives)**(Data Protection Act 2018/ Access to Health Records Act 1990) |

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| 1. **RECORD TYPE (please tick):**
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| How do you require access to be provided? **PHOTOCOPIES** **VIEW ONLY**  |
| Type of health records required: **HEALTH RECORDS X-RAYS PHOTOGRAPHS****PHYSIO COMMUNITY** **RECORDS TEAM RECORDS**  |

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| 1. **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:**

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| Previous Name: | Previous Address: |

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| 1. **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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| 1. **DECLARATION:**
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| I declare that the information given by me is correct to the best of my knowledge and that:\* I am the patient and attach a copy of photographic ID, and proof of address.\* 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 (grant of probate)\* 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:**

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| Your name:……………………..…………………..….…… Your relationship to the patient:……………………….…..…………….Your address:………………………………….….……………………………………………………………………………………..…...Your contact telephone number:……………………………………….………………………………………….………………………..Your email address: ………………………………………………………………………………………………………………………… |

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| 1. **AUTHORISATION:** (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:**

Records Department

Chippenham Hospital

Rowden Hill

Chippenham

SN15 2AJ

Or email: whc.recordsrequest@nhs.net