Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Application to Access Health Records (DPA1)

Before completion please read our accompanying leaflet 'Accessing Health Records' for important information on your rights to access and timescales

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PLEASE COMPLETE IN **BLOCK CAPITALS AND DARK INK**

1. The Patient

FULL NAME (Including Title)			
PREVIOUS NAME		**DATE OF BIRTH**	DD/MM/YY
HOSPITAL / NHS NUMBER	IF KNOWN		
CURRENT ADDRESS – INC POSTCODE		**PREVIOUS ADDRESS – INC POSTCODE**	
TELEPHONE NUMBER		**MOBILE NUMBER**	

2. For completion by the APPLICANT

□ Please tick if you are the patient and go straight to Section 3A. **If you are not the patient please complete section 2.1.**

2.1 FULL NAME (Including Title)			
PREVIOUS NAME		**DATE OF BIRTH**	DD/MM/YY
RELATIONSHIP TO PATIENT			
CURRENT ADDRESS – INC POSTCODE		**PREVIOUS ADDRESS – INC POSTCODE**	
TELEPHONE		**MOBILE**	

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NUMBER		NUMBER	

3. Declaration (please tick as appropriate)

You are advised that the making of a false or misleading statement in order to obtain access to personal information to which you are not entitled is a criminal offence.
I declare that the information given by me is correct to the best of my knowledge, that I am entitled to apply for access to health records referred to under the terms of the General Data Protection Regulation 2018 and that:

A	**I am the patient** (After signing in section 3.1 please go to section 4)	
B	**I have been asked to apply by the patient and completed within this form is the patient's written consent** (After signing in section 3.1 and 3.2 please go straight to section 4)	
C	**I am the patient's legally appointed personal representative and I attach confirmation of my appointment (e.g. Power of Attorney for Health)** (See 3.1 of the information for Patients leaflet, *Accessing Health Records*) (After signing in section 3.1 please go straight to section 4)	
D	**I have parental responsibility for a child under the age of 18, who is not competent to understanding the request and give their consent** (See Section 8 of the information for Patients leaflet, *Accessing Health records*) (After signing in section 3.1 please go straight to section 4)	
E	**I have parental responsibility for a child under the age of 18, who has consented to my making this request and has completed the written authorisation below** (Please note children aged 16 and 17 are regarded as adults for this purpose, and their consent must be obtained before a person with parental responsibility can be given access to their health records). (See section 8 of the Information for Patients leaflet, *Accessing Health Records*) (After signing in section 3.1 and 3.2 please go straight to section 4)	
F	**The patient is deceased and I am the deceased patients personal representative and I attach confirmation/documentary evidence of my appointment (e.g. Grant of Representation from the Probate Service or Letters of Administration)** (See 3.2 of the Information for Patients leaflet, *Accessing Health Records*) (After signing in section 3.1 please go straight to section 4)	
G	**I have evidence arising from the patient's death and I attach documentary evidence** (See 3.2 of the Information for Patients leaflet, *Accessing Health Records*) (After signing in section 3.1 please go straight to section 4)	
H	**Relevant to my claim on the grounds that:-** (Please detail) _____ _____ (After signing in section 3.1 please go to section 4)	

3.1Signature of Applicant: ……. Date: ……
(as indicated in Section 2)

3.2 Patient's written consent

To be completed if the Patient is giving the Applicant their consent to apply:
I hereby authorise Sherwood Forest Hospital NHS Foundation Trust to release my personal information as specified within this application to:

Name: …….. to whom I give consent to act on my behalf.

Signature of Patient: …… Date: ……
(as indicated in Section 1)

Please note: There are now **no fees** to be paid in order to access your medical notes under the General Data Protection Regulation 2018.

We do require identification when requesting any medical records. This is to ensure that all patient data is kept secure and is in accordance with our trust policy. Please see Section 4 for details.

4. Proof of Identity of the Patient/Applicant

It is essential to provide adequate proof of identification to permit us to establish your right of access to information under the General Data Protection Regulation 2018.
Please remember to submit the following documents when you submit this application.
EXAMPLES OF ACCEPTABLE DOCUMENTS:

- **If you are requesting copies of your own health records** (as indicated in Section 1)
  - □ 1 item to confirm your signature ***AND***
  - □ 1 item to confirm your address

Signature Documents	***Address Documents***
Passport	**Utility Bill**
Driving Licence	**Council Tax Bill**
	Bank Statement
	Credit Card Statement
	Insurance Letters/Docs

- **If you are requesting copies of health records on behalf of a patient** (as indicated in Section 2)
  - □ 1 Item to confirm the patient's signature
  - □ 1 Item to confirm the patient's address
  - □ 1 item to confirm your signature
  - □ 1 item to confirm your address

- **If you are requesting copies of a child's health records**
  - □ Birth Certificate or Passport for Child
  - □ 1 Item to confirm your signature
  - □ 1 Item to confirm your address

- **If you are requesting copies of health records of a deceased person**
  - □ 1 Item to confirm your signature
  - □ 1 Item to confirm your address
  - □ A copy of the Representation document confirming your appointment (e.g. Grant of Probate) ***OR*** evidence of your claim arising from the patient's death (e.g. Letter of instruction to Solicitor)

- **If you are requesting copies of health records for a patient that is not able to manage their own affairs**
  - □ 1 Item to confirm your signature
  - □ 1 Item to confirm your address
  - □ Copy of the Lasting Power of Attorney Document (LPA)

Signature Documents	***Address Documents***	***Representation Documents***
Passport	**Utility Bill**	Grant of Probate
Driving Licence	**Council Tax Bill**	Letters of Administration
Child's Documents	Bank Statement	Copy Of Will
Birth Certificate	Credit Card Statement	Power of Attorney
Passport	Insurance Letters/Docs	

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5. What information do you require?

We ask that you provide as much information as possible, giving full details of the information you wish to have access to. Please inform us specifically of which information you would like, it will help us deal with your enquiry more promptly and will keep the cost of supplying copies to a minimum.

Department / Ward / Clinic	Consultant	Date(s) of Episode
Any other details:		

I require (please tick):

□ Copies of written information only (health records)
□ Copies of computer data only
□ Copies of both computer data and written information
□ Copies of radiology images (x-rays & scans)

□ I want to **view only written records** and supply of copies is not required
(See Section 10 of the Information for Patients Leaflet, *Accessing Health Records*)

□ I want to **view only computer record**s and supply of copies is not required
(See Section 10 of the Information for Patients leaflet, *Accessing Health Records*)

□ If you require copies of your records for a Department of Social Security Tribunal, please indicate here:

_____
_____
_____
_____
_____

Should you require any further assistance on how to complete this application form, please do not hesitate to contact us by phone or email.

PLEASE NOTE:

Your application will be processed upon receipt of the completed application form and relevant ID. Failure to forward the required proof of identity may result in a *delay/refusal of your application*.

When you have completed the application and have the relevant ID, please bring/post/email your form to:

Kings Mill Hospital:

Access to Health Records
Sherwood Forest Hospitals NHS Foundation Trust
Kings Mill Hospital
Mansfield Road
Sutton In Ashfield
Nottinghamshire
NG17 4JL

Tel: 01623 672231 or 01623 622515 ext. 3233 or 3235
Email: sfh-tr.sar@nhs.net