

Application for Access to Health Records (Clinical)

Request No/.....

PLEASE COMPLETE IN BLOCK CAPITALS & BLACK INK

The General Data Protection Regulation (2016) gives every living person the right to apply for access to their health records. However, there are certain circumstances in which we may withhold information. Access may be denied or limited where the information might cause serious harm to the physical or mental health or condition of the patient, or any other person, or where giving access would disclose information relating to or provided by a third party who had not consented to the disclosure.

Patient Details

Surname:

Forename(s):.....

Former Name(s) - *if applicable*:.....

Date of Birth.....

NHS Number - *if known*:

Current Address

.....

Current Telephone Number:

Previous details (If different from above):

.....

.....

Applicant Details (*if different to details above*)

Full Name:

Current Address:

.....

.....

Relationship to patient:.....

Records

It would be helpful if you could provide details if there are any periods/parts of your health records you particularly wish to see:

.....
.....
.....
.....
.....
.....

Confidentiality

Patients have a right to have their personal health information kept confidential and we are obliged to check that an applicant is the patient, or is otherwise entitled to access that patient's records. It may be necessary for us to check your identity and make additional enquiries concerning the validity of your application.

Further information

This section is optional. However, it would be very helpful if the following details were provided. Is this application being made because legal proceedings are being considered against the Hospice or one of its employees? YES/NO

If YES please provide details:

.....
.....

Declaration:

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record referred to above, under the terms of the General Data Protection Regulation or Access to Health Records Act 1990 for the following reason:

Please delete as appropriate

- **I am the patient**
- **I am nominated to act on behalf of the named person and enclose evidence to this effect.**
- **I have parental responsibility and the child is under age 16.**
- **I am the deceased patient's personal representative.**

WARNING

You are advised that making a false or misleading statement in order to obtain access to personal information to which you are not entitled is a criminal offence

Signed

Print Name

Date

To process this application, two forms of ID may be requested e.g.:

- **Driving Licence**
- **Passport**
- **Household Bill**
- **If accessing the records of a child, a copy of the birth certificate will be required.**

Return this Form to:

**Clinical Admin Office
St Nicholas Hospice Care
Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QY**