**Application for Access to Health Records**

**(ESNEFT Hospitals)**

(In accordance with the Data Protection Act 2018/Access to Health Records Act 1990)

**Please complete this form in BLOCK CAPITALS and return to the address overleaf**

When the completed application form is received by the Access to Health Records Team, a strict process in undertaken. You should receive a response from us within one calendar month of receiving your request.

**Where did the patient attend?**

* Colchester Hospital
* Clacton Hospital
* Harwich Hospital
* Ipswich Hospital (includes Aldeburgh Cottage, Bluebird Lodge and Felixstowe General)
* All of the above

**Section 1 - The patient the information relates to:**

|  |
| --- |
| Surname: ………………………….............. Forenames: ………………………………………  Current address: ……………………………………………………………………..………  Post Code:..………………………  Date of birth: …………………............................  Hospital/NHS no.:……………….......................  Telephone Number: …………………………….  Mobile Number: ………………………………….  Email Address………………………………………………………………………… |

Surname: ………………………….............. Forenames: ………………………………………

Current address: ……………………………………………………………………..………………

………………………………………......…… Post Code: ..………………………

Date of birth: …………………............................

Hospital/NHS no.: ……………….......................

Telephone Number: …………………………….

Mobile Number: ………………………………….

I enclose a copy of one of the following as proof of the identity of the above individual:

* Birth certificate
* Driving licence
* Passport

If none of these is available please contact the Data Protection Officer for advice on other acceptable forms of identification.

**Section 2 - Is the requested information about you?**

No, the information is not about me (go to section 3)

Yes, the information is about me (go to section 6 )

**Please note: If information to be disclosed includes incidental disclosure of third party (for example family member, referee, care worker) it cannot be disclosed without the consent of that party.**

**Section 3 - The person acting on behalf of the patient:**

|  |
| --- |
| Surname: ………………………….............. Forenames: ………………………………………  Current address: ……………………………………………………………………..………  Post Code:..………………………  Contact Number: …………………………….  Email Address………………………………………………………… |

Please provide proof that you are the person authorised to act on behalf of the data subject by enclose a copy of one of the following:

* Birth certificate
* Driving licence
* Passport

If the data subject is under 16, do you have parental responsibility for them?

Yes □

No □

**Section 4 – Legal Requirements for Deceased Patients.**

Please provide proof that you are legally authorised to act on the data subject’s behalf in the form of:

* Evidence of parental responsibility for under 16 year olds
* Letter of Administration / Grant of Probate
* The patient’s Will with you named as executor.

**Section 5 – Legal Requirements for Living patients.**

Please provide proof that you are legally authorised to act on the data subject’s behalf in the form of:

Please provide proof that you are legally authorised to act on the data subject’s behalf in the form of:

* Power of Attorney
* Patient’s signed consent
* If for child under 16 please supply **full** birth certificate.

**Section 6 – What is the nature of the request you are making?**

Please help us deal with your request quickly and efficiently by giving as much detail as possible about the information you want. If possible restrict your request to a particular department, period of time or incident.

**Information requested in more detail: (please use a separate sheet of paper if required)**

**Information requested covers (dates)**

From: To:

Relevant details to help us locate the information (for example address at the time, service or department, names of previous contacts, any file reference if known)

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**Section 7 - Access to the information**

**Please tick which format you require records to be sent via:**

**Email Paper USB**

**Please supply a postal address if different to the patient’s:**

**…………………………………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………………**

**Section 8 - Declaration and authorisation:**

**Warning – a person who unlawfully obtains or attempts to obtain personal information is guilty of a criminal offence and is liable to prosecution.**

I declare that the information I have completed on this form is correct to the best of my knowledge and that: (\*please tick below as appropriate)

\* I am the person named in Section 1 (please sign Signature 1 below)

\* I am acting on behalf of the person named in Section 1 (please sign Signature 2 below)

\* I am the Legal Representative – for information relating to deceased patients only

(please sign Signature 3 below)

**Signature 1** (if you are the person named in section 1 of this form)

I (insert full name in BLOCK capitals) ………………………………………………………………

certify that I am the person named overleaf.

Signed: …………………………………………………….. Date: ……………………………………

**Signature 2** (if you are acting on behalf of the living person named in section1

I (insert full name in BLOCK capitals) ………………………………………………………………

Signed: …………………………………………………… Date: ……………………………………

* Parent/Guardian
* Legal Representative.

**Signature 3** (if you are the legal representative – for information relating to deceased patients **only**)

I (insert full name in BLOCK capitals) …………………………………………………………………

certify that I am the Legal Representative to the person named in Section 1.

Signed: ………………………………………………….. Date: ………….……………………………

**Please check that you have completed all fields of the form and all details are correct.**

**Please return this completed form, along with accompanying documents of the relevant identification/certification to:**

Access to Health Records Dept.

Colchester Hospital,

Health Records Centre,

Turner Road,

Colchester,

CO4 5JL

Tel: 01206 742127

Email – [SAResneft@esneft.nhs.uk](mailto:SAResneft@esneft.nhs.uk) (preferred)

**This form will be kept for a minimum of 3 years by the access to health records team. It will then be confidentially destroyed, this follows the National Guidance Records Management NHS Code of Practice Retention Schedule 2016**