

APPLICATION FOR ACCESS TO HEALTH RECORDS (Form SAR 1)

Please complete **Sections 1, 2, 3 and 4.**

Sections 5 and 6 are to be completed if applicable.

All Sections are to be completed in CAPITAL LETTERS.

Please provide as much information as possible which may be of assistance to the Trust in processing your request.

Incomplete forms will be returned which may in turn delay the processing of your request. Please refer to the separate information sheet '**Information for Applicants**' in completing this form.

Section 1 – Personal details	
1. Full Name of Patient (Mr/Mrs/Miss/Ms)	5. Any Former Address
Surname	
Forename	
Any Other Forename	
2. Date of Birth (dd/mm/yy)	6. NHS/ Hospital Number (if known)
3. Contact Telephone Number	7. Surname and Forename of Applicant (if different from above)
4. Current Address (inc postcode)	8. Address to which reply should be sent (if different from that of patient)

Section 2 – Details of the record to be accessed

Please use this form to request multiple or single document types e.g. *if you require copies of the Maternity Record and Main Health Records*; please do not submit separate forms for each request.

Please complete **Step 1** and **Step 2** below

Step 1 ; Please circle which Record Type(s) you require copies of-:

Medical Record A&E Record X- Rays Physiotherapy Record Maternity Record

Step 2 ; Please provide details of the episode/parts of your health records you require copies of using the table below:

Ward/Clinic attended (with dates):	Consultant (s) (if known):

Please use the space below to provide us with any additional information in order to meet your request to access your health record (attach additional information if necessary).....

I have attached additional information

If you wish to **View your Records** only, please complete **step 2** and indicate below - you will then be contacted to make an appointment.

In order to process your request, two types of identification will be required from you.

Section 3 – Identification

What identification has been included as part of your application. Please do not provide originals.

Passport <input type="checkbox"/>	Birth Certificate <input type="checkbox"/>
Driving Licence <input type="checkbox"/>	Other (please identify) <input type="checkbox"/>

Section 4 – 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 Regulations (2018) and/or Access to Health Records Act (1990).

Please tick one of the following boxes:

I am the patient <input type="checkbox"/>	I have been appointed the Guardian for the patient , who is over age 16 under a Guardianship order <input type="checkbox"/>
I have been asked to act by the patient and have completed Part 1 of the following authorisation. <input type="checkbox"/>	I am the deceased patient’s personal representative and attach confirmation of my appointment <input type="checkbox"/>
I have parental responsibility/legal guardianship for the patient who is under 16 and [is incapable of understanding the request] or [has consented to me making the request] (delete as appropriate). <input type="checkbox"/>	I have a claim arising from the patient’s death and wish to access information relevant to my claim – the information will support my claim for the following reasons: (attach additional information if necessary)
I have completed Part 2 of this declaration, together with the child’s authorisation (if applicable).	
I have Lasting Power of Attorney for the patient (please attached LPA documentation) <input type="checkbox"/>	

I have read the ‘Information for Applicants’ information sheet and authorise a request to access health records to be carried out. I enclose two forms of identification.

Applicant’s Signature _____ Date: _____

Section 5: Authorisation Part 1 (to be completed only when acting on behalf of another person)

I _____ (print name) hereby authorise the Royal United Hospitals Bath NHS Foundation Trust to release any personal health records it may hold relating to me to _____ (insert name of person acting on your behalf) to whom I have given consent to act on my behalf.

Signed: _____

Date: _____

Section 6: Authorisation Part 2 (to be completed only in the case of a person under the age of 16)

I _____ (name of applicant)
of _____ (insert address)

certify that the patient understands /is incapable of understanding* the nature of this application (*delete as appropriate)

Signed: _____

Date: _____

Childs signature (if patient understands)

Date: _____

Completed Forms:

Completed forms should be sent to:
Medical Records Manager
Health Informatics Department
Apley House (E5)
Royal United Hospitals Bath NHS Foundation Trust
Combe Park
BATH
BA1 3NG

Official Use Only

Pre-processing Check:	
<input type="checkbox"/> Sufficient details to process application	(Date)...../...../..... signed.....
'NO': Letter sent to seek further information	(date)...../...../..... signed.....
Processing of Request:	
Added to SAR Database	(Date)...../...../.....
.....	Signed.....