Royal United Hospitals Bath NHS
NHS Foundation Trust

APPLICATION FOR ACCESS TO HEALTH RECORDS

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	**5.** Any Former Address
(Mr/Mrs/Miss/Ms)	
Surname	
Forename	
Any Other Forename	**6.** Hospital Number (if known)
2. Date of Birth (ddmmyy)	**7.** Surname and Forename of Applicant (if different from above)
3. Contact Telephone Number	**8.** Address to which reply should be sent (if different from that of patient)
4. Current Address (inc postcode)	

Section 2 – Details of the record to be accessed

Please tick relevant box. Tick 'View Health Records/Read Only' to view your health record. If you require a full copy of your health record, please tick 'Full Copy of Health Records'. If a specific part of your record is required for a hospital attendance, tick 'Partial Copy of Health Record'.

Access to Records regarding Complaints about Healthcare
If you require copies of your records with regards to a complaint about an episode of Healthcare please tick box ☐.
Please note in these instances only information specific to the complaint will be provided, please provide episode details relating to the complaint in the 'Partial Copies' section below.

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.

View Health Records Only ☐	Partial Copy of Health Record (please detail below) ☐
Full Copy of Health Records ☐	Copy of Imaging (Xray,CT Scan, MRI, Ultrasounds) ☐
Full copy of Maternity Records ☐	Partial Copy of Maternity Record ☐

Please delete from the list below the records you **do not** wish to have access to:

Medical Record   A & E Record   X- Rays   Physiotherapy Record

Maternity Record

Partial Copy - 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 view or access your health record (attach additional information if necessary)…………………………………………………………………………………………………

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I have attached additional information ☐

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 ☐	Birth Certificate ☐
Driving Licence ☐	Other (please identify) ☐

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 Data Protection Act 1998 and Access to Health Records Act 1990.	
Please tick one of the following boxes:	
I am the patient ☐	I have been appointed the Guardian for the patient , who is over age 16 under a Guardianship order ☐
I have been asked to act by the patient and have completed **Part 1** of the following authorisation. ☐	I am the deceased patient's personal representaive and attach confirmation of my appointment ☐
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 appropriately). ☐ I have completed **Part 2** of this declaration, together with the child's authorisation (if applicable).	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 read the 'Information for Applicants' information sheet and authorise a request to access health records to be carried out. I understand that a fee may be required prior to the release of any information and that payment will be required in full before despatch of notes. I enclose two forms of identification. Applicant's Signtaure________________________________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 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
Royal United Hospitals NHS Foundation Trust
Combe Park
BATH
BA1 3NG

Official Use Only

Pre-processing Check:	
☐ Sufficient details to process application	(Date)……../……../………. signed………………………
'NO': Letter sent to seek further information	(date)……/………/……… signed…………………… .

Administration Fee:	

☐ £10.00 received/not appropriate/to be charged ☐ £50.00 received/not appropriate/to be charged ☐ Other Fee charged………………………………	(Date)……./……./…….. Signed………………….......

Processing of Request: Name of Lead Health Professional ……………………………………………………………. Outcome: ☐ Appointment to be made with Lead Heath Professional ☐ Supervised appointment to be made ☐ Copies of notes to be sent ☐ Applicant advised of applicant	Consent Requested (date)………/…………/………… Signed………………………………………………….. Date of appt………../………../……. Time:…………….. Date of appt………/………./……… Time:…………….

Processing Application: Further Action Required: YES/NO (Comment opposite) Access provided on (date)………/…....…../………….. Copies provided on (date)………/…………/……….. …	Comments …………………………………………………………… …………………………………………………………… ……………………………………………………………