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**Application for access to health records of a living individual**

**Data Protection Act 2018**

**and**

**General Data Protection Regulation (GDPR)**

Case Number [for office use only]

Please complete all details in the application form. You will also need to provide proof of your identity before the application can be processed.

**Details of the record to be accessed**

|  |  |
| --- | --- |
| Patient full name | Former name(s) |
| Current address | Former address (if known) |
| Date of birth | NHS number (if known) |
| Contact phone number (landline including area code) | Mobile phone number |

 **Details of applicant (if different from above)**

|  |  |
| --- | --- |
| Full name | Contact phone number (landline including area code) |
| Address | Mobile phone number |
| Relationship to living individual  |  |

 **Please tick the appropriate box and supply relevant information where required to do so:**

□ I am the individual

□ I am acting on behalf of the individual.

If you are applying on behalf of an individual you must ensure that the individual has provided their written consent for you to do so (if they are capable of giving consent). The additional written consent is not required if the application is supported by legal documentation authorising you to act on their behalf or the individual is a child. Please see guidance notes.

You do not have to give a reason for applying for access to health records. However, it will help the clinician to make a decision regarding release of the information if he / she understands your reasons for making the application.

Reason for application

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

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

To speed up your request, it would be helpful if you could provide details about the periods and parts of the health record(s) you require, along with details which you may feel have relevance i.e. consultant name, written diagnosis and reports etc.

Please use the table below to document this information.

|  |  |  |
| --- | --- | --- |
| **Date** | **Type of record** | **Consultant or clinician’s name (if known)** |
|  |  |  |

**Please tick the appropriate box below:**

* I am applying for access to view the health records
* I am applying for copies of the health records

**Declaration to be completed by individual applying for their own records or a person applying on behalf of the patient**

*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 stated on the**application form**under the terms of the***Data Protection Act 2018 and GDPR.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please print name here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Declaration – Third Party (to be completed by the individual applying on behalf of the patient)****\*Delete as appropriate\*** |
| **Power of Attorney**I am acting on behalf of the Data Subject (patient) who lacks capacity to consent as defined by the Mental Capacity Act 2005.   I hold a \*Power of Attorney / I have been appointed as an independent Mental Capacity Advocate\* to act on behalf of the Data Subject and have attached evidence.**Parental responsibility**I have \*sole / joint\* parental responsibility for the Data Subject and they \*lack capacity to understand the request / has consented to the request\*.(18 year old if individual has learning disabilities). **Consent**I am applying on behalf of the Data Subject to access their records and have attached their consent.I understand there may be a charge for me to be provided with a copy.   I have enclosed proof of my identity and other documents as required and as set out in the table on page 2.Your name (BLOCK CAPITALS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Your signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**You can return your completed form to any of the following addresses for processing, but it is advisable to return the form to the health records department of the geographical area you have been treated in. Please note that if you have been treated in the WAKEFIELD area you will need to return your form to the BARNSLEY health records office.**

**The addresses for the 4 health records departments are:**

**Health Records Department**

**The Dales**

**Calderdale Royal Hospital**

**Huddersfield Road**

**Salterhebble**

**HALIFAX**

**HX3 0PW**

**Health Records Department**

**Priestley Unit**

**Dewsbury & District Hospital**

**Halifax Road**

**DEWSBURY**

**WF13 4HS**

**Health Records Department**

**Folly Hall Mills**

**St Thomas Road**

**HUDDERSFIELD**

**HD1 3LT**

**Health Records Department**

**Information Services**

**Oaks Unit**

**Kendray Hospital**

**Doncaster Road**

**BARNSLEY**

**S70 3RD**

**(Office use only)**

|  |  |
| --- | --- |
| **Date application form received:** |  |
| **Received by:** |  |
| **Signed by:** |  |
| **Proof of identity received with form** | **Yes / No** |
| **List documentation received as proof of identity** |  |

**\*Warning\***

**Application must not be processed unless correct forms of identification have been received and the application is valid.**