**APPLICATION FOR ACCESS TO HEALTH RECORDS **

(General Data Protection Regulations 2018)

**Please complete all the sections of this form.**

**PATIENT DETAILS**

|  |  |
| --- | --- |
| **PATIENT NAME** |  |
| **CURRENT ADDRESS** |  |
| **POSTCODE** |  |
| **DATE OF BIRTH** |  |
| **DAYTIME TELEPHONE NUMBER** |  |

**PREVIOUS NAME OR ADDRESS** (If your name or address has changed since your procedure)

|  |  |
| --- | --- |
| **NAME** |  |
| **PREVIOUS ADDRESS** |  |
| **POSTCODE** |  |

Note: Please continue on a separate sheet if you have several previous addresses or name changes.

**RECORD IN RESPECT OF TREATMENT/PROCEDURE**

Please state Treatment/Procedure (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Date of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Number (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason information is required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consultant/Clinician Name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is anything you specifically require (records relating to a particular consultant, within specific dates or a specific procedure), please complete above or, for more than one record, please attach a separate sheet with this information.

**DECLARATION: I declare that I am the patient, that the information provided 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 2018. I have enclosed a copy of my photo ID with this request.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am not the patient and the information provided by me is correct to the best of my knowledge. However, I am a legal representative of the patient such as power of attorney.** (Please supply a copy of this documentation and a copy of your photo ID with this request). **I am entitled to apply for Access to the Health Record referred to above under the terms of the General Data Protection Regulation 2018.**

Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Status to act as the patient’s representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please email the completed form to: medicalrecords.requests@transform.com**

**FOR OFFICE USE ONLY:**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Records/Info Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeon/Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_