APPLICATION FOR ACCESS TO HEALTH RECORDS
(General Data Protection Regulations 2018)
Please complete all the sections of this form.

TRANSFORM
Cosmetic Surgery

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.

Please circle which means of access to your records you would like copies or **viewing**

As medical records are legal documents and belong to Transform any viewings of notes will take place under supervision and you will be required to bring photo id with you in order to view the health records.

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. If you have opted to view the health records, please bring the original copies of your photo id and legal representative documentation). 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 return the completed form to: Medical Records Department, Pines Hospital, Sharston, Manchester, M22 4RZ.

FOR OFFICE USE ONLY:

Signed: _____ Date Records/Info Sent: _____

Date: _____ Hospital Number: _____

Surgeon/Clinician: _____