Walsall Healthcare NHS
NHS Trust

Application for information from Manual / Computerised Records under the General Data Protection Regulation

Please note there will no longer be a charge for accessing your medical records, However, we can charge a 'reasonable fee' when a request is deemed repetitive or excessive.

We have 30 days to comply with GDPR, the 30 days start from the date we receive a fully completed application form which gives us the relevant information to proceed. Please note that Under GDPR where requests are complex or numerous, the period of compliance can be increased by a further two months, If this is the case for your request, you will be notified by letter within 30 days of receipt of your completed form

SECTION 1 – Details of Patient (if you are the patient, please complete this section and then go to section 3). If you are not the patient, complete 1 and 2 before completing section 3.

Hospital Unit No: ……………………………..…. NHS Number………………………………………….........

Surname: ……………………..………………… Forename(s): ……………………………………………… .

Title (Dr, Mr, Mrs, Miss Ms (Other): ………

Date of Birth: ………………………………… Daytime Telephone Number: ………………………......

Current Address: …………..…………………………………………………………………………………….

……………………………………………….. Postcode: ………………………………………………….

IF YOUR/THE NAME AND/OR ADDRESS WAS DIFFERENT FROM THE ABOVE DURING THE PERIOD(S) TO WHICH YOUR APPLICATION RELATES, PLEASE GIVE DETAILS:

PREVIOUS NAME:	PREVIOUS ADDRESS:	DATE(S) APPLICABLE:

PATIENT HOSPITAL OR CLINIC CONTACTS

Please provide as much information as possible. Give full details of all the episodes of treatment you wish to have access to, this would also include any x-rays/CT/MRI scans you may have had also.

HOSPITAL/CLINIC ATTENDED	DATE	WARD/DEPARTMENT OUTPATIENT CLINIC	NAME OF CONSULTANT	CASENOTE NUMBER

SECTION 2 - Details of Applicant (complete this section if you are not the patient)

Surname ………………………………… Forename(s) ……………………………. Title ……………………….

Address ……...

Post Code …………………. Tel No ……………………… Relationship to Patient …………………………….

SECTION 3 – Please tick box below as appropriate

- ☐ I am the patient
- ☐ I have been asked to act by the patient and attach the patient's written authorisation
- ☐ I am the legal parent/guardian of the patient and as such have responsibility for the patient who is under the age of 16 years. NB Formal evidence of this responsibility may be required.
- ☐ The patient is incapable of managing his/her own affairs and I am appointed by the Courts to manage those affairs. I attach proof of my appointment.
- ☐ I am the deceased patient's personal representative, i.e. Executor of Will (attach confirmation of appointment
- ☐ I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that

……………………………………………………………………………………..

SECTION 4 – Please tick the correct box below if you wish to view your records or have photocopies of your medical records sent to you by post

- ☐ I wish to come to view my/the patient's records with a lay person or Health Records representative. (no medical information will be discussed at this session).
- ☐ Please send me photocopies of the records relating to treatment received as detailed in section 1 of this form

SECTION 6 – Please read the paragraph below and sign in the appropriate place(s)

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 records referred to, under the terms of the General Data Protection Regulation

Signed …………………………. Full Name ………………..…………………… Date ………………………

Proof of ID and address will be required such as driving licence or passport

Please return this form, when completed to:

The Access to Health Records Team
c/o The Health Records Library, Walsall Healthcare NHS Trust, Manor Hospital, Moat Road, Walsall, WS2 9PS.