

**APPLICATION FORM FOR ACCESS TO HEALTH RECORDS**

**PLEASE COMPLETE IN BLOCK CAPITALS**

All access to health records requests are dealt with in compliance with the Data Protection Act (1998). If you require access to information written more than 40 days before your application, a fee for copying is charged on a sliding scale up to a maximum of £50.00. All fees will be invoiced before disclosure, however please do not send any money with this application form.

**DETAILS OF PERSON WHO'S RECORDS ARE REQUESTED:**

Patient Surname:		Mr/Mrs/Ms	Date of Birth:	
Forenames:			Hospital Ref: (if known)	K
Current Address			Post Code:	
			Telephone Number:	

If your name and/or address was different from the above during the period(s) to which your application relates, please give details below:

Previous Surname:	(1)	(2)
Address:		
Applicable dates:		

**PATIENT'S HOSPITAL or CLINIC CONTACTS**

Please give full details of all the information you wish to have access to:-

Data requested	Hospital/Ward/Clinic	Relevant Dates	Consultant (if known)
Copies of Medical Records			

**DECLARATION**

I declare that the information given in this form is correct to the best of my knowledge, and that:

- \* I am the person named overleaf
- \* I am acting on behalf of the person named overleaf (\*delete as appropriate)

**IMPORTANT NOTE:**

- ◆ This section of the form must be signed in the presence of the person who countersigns your application.
- ◆ If you are acting on behalf of another person, PART 1 of the AUTHORISATION section below must also be completed.
- ◆ In the case of a person under 18 years, PART 2 of the AUTHORISATION section below must also be completed

Applicant's Name: (print in CAPITALS) .....

Address to which reply should be sent: (if different from overleaf) .....

.....

Signature: ..... Date: .....

**AUTHORISATION**

**PART 1 – ON BEHALF OF THE PATIENT**

I hereby authorise The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to release the requested medical information to:

.....(enter name of person acting on your behalf)

Signature: ..... Date: .....

**PART 2** (in the case of a person under the age of 18, a responsible adult should certify, where appropriate, that the child understands the nature of the application)

I, (Name) .....

of (Address) .....

certify that the applicant understands the nature of this application.

Signature: ..... Date: .....

**COUNTERSIGNATURE** (to be completed by the person required to confirm identity)

I (insert full name): ..... certify that the applicant (insert full name)

.....has been known to me as an employee/client/patient/personal friend for ....

years and that I have witnessed the signing of the above declaration.

Signature: ..... Date: .....

Name: ..... Profession: .....

Address: .....

Daytime telephone number: .....