The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

APPLICATION FORM FOR ACCESS TO HEALTH RECORDS

PLEASE COMPLETE IN BLOCK CAPITALS WITH A BLACK PEN

All access to health records requests are dealt with in compliance with the Data Protection Act (2018).

PLEASE GIVE US THE FOLLOWING INFORMATION ABOUT THE PATIENT

Surname:		Mr/Mrs/Ms	Date of Birth:	
Forenames:			Hospital Ref: (if	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			

Please return completed form to: Access to Health Records, Legal Services, The Queen Elizabeth Hospital, Gayton Road, King's Lynn PE30 4ET

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 Kings Lynn NHS 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: .....

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