###### Application for Access to Health Records

(Data Protection Act 1998 / Access to Health Records Act 1990)

**Please Note:**

* This form should be used for all Stockport NHS Foundation Trust records including Stockport Community Healthcare records.
* There is a **charge** for this service – please contact the Patient & Customer Services Department for further details on 0161 419 5425 or visit our website.
* This form may be completed on-line but not submitted on-line as it requires your signature.
* Completed forms should be sent to Patient & Customer Services, Medico Legal Team, Stockport NHS Foundation Trust, Stepping Hill Hospital, Poplar Grove, Stockport, SK2 7JE.
* Please ensure **all** relevant documentation is attached, including consent\* (if applicable) and photocopies of either (the applicants) driving license or passport. If these documents are **not** available please ensure the certification is signed.
* Please ensure that any consent/certification is dated within the last 6 months.
* See our website ([www.stockport.nhs.uk](http://www.stockport.nhs.uk/)) for more details.

**Patient Details:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patients full name: | | |  | | | | | |
| Previous name (If applicable): | | |  | | | | | |
| Date of birth: | Date of death  (if applicable): | | Hospital unit number: | | | NHS number: | | |
|  |  | |  | | |  | | |
| Most recent / last known address: | | | | Any known previous address: | | | | |
|  | | | |  | | | | |
| Email address (optional): | |  | | | | | | |
| Contact phone number: | |  | | | | | | |
| Date of accident (if applicable): | |  | | | Date (s) of treatment: | | - | |
| Consultant / department name: | |  | | | | | | |
| Brief description of treatment: | |  | | | | | | |
| Clinic / hospital site name: | |  | | | | | | |
| Are x-rays required (Yes/No)? | | | | | | | |  |
| Are physiotherapy records required (Yes/No)? | | | | | | | |  |
| Disclaimer - is this in relation to a claim against Stockport NHS Foundation Trust (Yes/No)? | | | | | | | |  |

**Applicant Details:**

If you are not the patient named above, please supply the following information:

|  |  |
| --- | --- |
| Your name: |  |
| Relationship to patient: |  |
| Your address: |  |
| Contact phone number: |  |
| Email address (optional): |  |

|  |  |
| --- | --- |
| I am the patient |  |
| The patient has died and I am their next of Kin. |  |
| The patient has died and I am acting as their personal representative. I attach confirmation of my appointment. |  |
| The patient has asked me to act for them and, and I attach the patients written authorisation/consent. |  |
| The patient is incapable of understanding the request and I attach confirmation of my appointment. |  |
| I have parental responsibility for the patient who is under 16. He/She is incapable of understanding the request. |  |
| I have parental responsibility for the patient who is under 16. He/She has consented to my making this request (please attach consent). |  |
| Other (Please give details) |  |

Please place an (√) next to all that apply:

|  |  |
| --- | --- |
| I am applying for access to view health records |  |
| I am applying for copies of health record |  |

Type of access request (please √):

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of **applicant:** |  | Print name: |  |
| Date: |  | Contact telephone number: |  |

**Declaration:** 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 above under the terms of Data Protection Act 1998 / Access to Health Records Act 1990.

**Certification\* (if applicable):** I certify that I am **name** of **address** and that I have known the applicant for  years and have witnessed the applicant sign this form.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of **witness:\*** |  | Print name: |  |
| Date: |  | Contact telephone number: |  |

**\*This person must have known the applicant for 3+ years, or be a person of standing in the community e.g. a solicitor and must not be a relative.**

**Checklist:**

Before sending this form please check that you have completed this form in as much detail as possible & that you have:

* Signed and dated the form
* If you are acting on the patient’s behalf; enclosed the patient’s consent or confirmation of your appointment.
* Enclosed your identity documents **or** had a witness sign the certification. Please Note: The cost of your application will be calculated on receipt and you will be contacted for payment before the application is processed.