###### Application for Access to Health Records - Patients

(Data Protection Act 2018 / Access to Health Records Act 1990)

**Please Note:**

* It would help us to locate your information if this form is used when requesting information held by Stockport NHS Foundation Trust records including Stockport Community Healthcare records. If community records are required, please detail when and where treatment was provided to assist us locating any records not held centrally.
* Completed forms and **copies** of ID documents should be sent to:

**Subject Access Request Team, Stockport NHS Foundation Trust, Stepping Hill Hospital, Poplar Grove, Stockport, SK2 7JE** or electronically to [subjectaccessrequest@stockport.nhs.uk](mailto:subjectaccessrequest@stockport.nhs.uk)

.

* **Please ensure copies of all relevant documents are attached, (if applicable) and photocopies of either (the applicant’s) photo card driving licence or passport and 1 x utility bill that is no more than 6 months old, and which evidences the current home address. If these documents are not available, please contact the Subject Access Request Team on 0161 419 5425.**
* **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 | |  | | | | | | |
| Contact phone number: | |  | | | | | | |
| Date of accident (if applicable): | |  | | | Date (s) of treatment: | | - | |
| Consultant / department name: | |  | | | | | | |
| **Details of records required and or treatment received** | |  | | | | | | |
| Clinic / hospital site name: | |  | | | | | | |
| Are radiology images required (X-ray / MRI / CT / Ultrasound etc.) – 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: |  |
| **Please list the relevant documents to support your application:**  . |  |

|  |  |
| --- | --- |
| 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 (Administrator of the Estate / Executor of the Will etc.) |  |
| 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  (Power of Attorney covering Health and Welfare) |  |
| I have parental responsibility for the patient who is under 16. He / She is incapable of understanding the request. I have attached evidence of my parental responsibility (Birth Certificate, Appointment, Order etc.) |  |
| I have parental responsibility for the patient who is under 16. He/she has consented to my making this request (please attach consent). I have attached evidence of my parental responsibility (Birth Certificate, Appointment, Order etc.) |  |
| Other (please attach details and evidence of authority) |  |

**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.**

|  |  |  |  |
| --- | --- | --- | --- |
| 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 2018 / Access to Health Records Act 1990. | | | |
| Signature of **applicant**: |  | Print name: |  |
| Date: |  | Contact telephone number: |  |
|  | | | |
| Signature of **patient**: |  | Print name: |  |
| Date: |  | Contact telephone number: |  |