Stockport NHS Foundation Trust

Application for Access to Health Records

(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.
- 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 **copies of all** relevant documents are attached, (if applicable) and **photocopies** of either (the applicant's) photocard 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 Medico Legal Dept. on 0161 419 5425.
- Please ensure that any consent/certification is dated within the last 6 months.
- See our website (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:			
Further details of treatment received or records required:			
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 (optional):	

NHS Stockport NHS Foundation Trust

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

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)	

Type of access request (please √):

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

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:	

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.**

View only requests:			
Official use only - Note to staff members: Please return a copy of this form to Patient & Customer Services, Medico Legal Department. Please do not detach this section of the form.			
Medico Legal DP or HR reference:		**Access provided on** (date)	
Health professional advising (Full name)			
Signed:		**Date signed:**	
Further action where applicable (please (√) all that apply)			
Corrections requested:		Applicant notified of outcome:	
Copies requested / provided* (*delete as applicable): NB: Requests for copies should be directed to the Medico Legal Team.			
Comments:			