

**SUBJECT ACCESS REQUEST: HEALTH RECORDS**

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| **Patient’s Full Name** |  |
| **Date of Birth** |  |
| **Current Address & Postcode** |  |
| **Contact Telephone Number** |  |
| **Hospital Unit Number (if known)** |  |
| **NHS Number (if known)** |  |
| **Previous Address, if different at time of treatment** |  |
| **Do you only wish to view your records?** | YES/NO |
| **Do you require a copy of your Health Records for a specific period of time and/or date?** | YES, please specify the date(s):  or  NO |
| **Do you require a copy of all of your Health Records?** | YES/NO |
| **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 under the terms of The Data Protection Act 2018 (subject access requests/the right of access). **Tick as appropriate:**     I am the patient   I am a Police Officer / Law enforcement   I have been duly authorised to act by the patient and attach the patient’s written authorisation\* (\*confirm with patient the scope of health records requested)   I have parental responsibility for the patient who is under the age of 18 and has consented to my making this request\*\* (\*\*confirm with the child the scope of health records requested; for complex requests relating to a child refer to DPO and/or <https://ico.org.uk>)   I have parental responsibility for the patient who is incapable of understanding the nature of this request (authorisation attached) which is required on the grounds that: | |
| **Identification** | |
| In order to maintain confidentiality and to confirm your identity, before copies of the Health Records are released, please provide a copy of  **Tick as appropriate**   Driving Licence   or passport   or birth certificate, Certificate of Registry of Birth or Adoption Certificate   plus, a recent utility bill showing name and address (less than 3 months old) | |
| **I wish Health Record to be provided in the following format: Tick as appropriate**   Updates as agreed, to third party, via encrypted email   Paper copy to be sent to my home address by recorded delivery   Paper copy to my representative at the following address:   \*Paper copy for my collection from Pioneer Wound Healing & Lymphoedema Centres   \*Paper copy for my viewing at a Pioneer Wound Healing & Lymphoedema Centres  **\*** To protect your information, if collecting or wishing to view please bring a form of photo identification with you.   Scanned document sent to my private unsecure email address (please be aware that the use of a private unsecure email places your information at risk of being seen by other people)   Encrypted scanned document sent to my private secure email address:   Encrypted scanned document sent to my representative at their secure email address:   Other, please state preference: | |
| **Identity Verified: YES/NO Pioneer Administrator Signed: ………………………………**  **Requestor Name (capitals): ……………………………………………………………………….**  **Requestor Signature: …………………………………………… Date: …………………………** | |