Application for access to health records under the Access to Health Records Act 1990 (deceased patient records)

Please complete using **BLOCK CAPITALS** and provide as much information as possible. If necessary please continue on a separate sheet and enclose with your application.

**Proof of identity and right of access:**

To support your application the Trust will require proof of your identity and right of access to the deceased patient’s records. **Please therefore provide a copy your passport, photo driving licence or sufficient equivalent photo-identification**. Two recent utility bills are acceptable.

If you are the patient’s legally appointed personal representative please send a copy of either the Grant of Representation/Probate naming you as Executor, or the Letters of Administration naming you as Administrator for the estate. Please ensure that these are original or legally certified copies issued by the Court.

If you have a claim arising from the patient’s death you are required to send documentary evidence to support this. Please note you will need an original or certified copy of a letter from a solicitor detailing the grounds of your claim, as well as associated documentation demonstrating your relationship with the deceased.

**Procedure:**

Applications will be processed in accordance with the Access to Health Records Act 1990 and the Trust will aim to provide you with a response regarding the outcome of your application within 21 – 40 calendar days of receiving the fully completed request, proof of identity, and relevant supporting documentation.

Records will be provided electronically via the Care Information Exchange (where all records are required), sent via secure email, by post,or made available for collection free of charge. Please be aware however that you will need to bring proof of identity with you should you wish to do this, and liaise with the Health Records team to agree a date/time. **Please be advised however that we will only be able to store them for you for 1 month, following which they will be confidentially destroyed. Should you submit a further application for the same records, then a fee for a repeat request may be applicable.**

Please also note that should your request relate to excessive records, or is a repeat request, then charges may be applicable.

Copies of x-rays/scans may be provided on discs which will be encrypted with a password and sent to you separately from the Imaging Department.

**SECTION 1: Records to be accessed (patient’s details)**

|  |  |
| --- | --- |
| Title: |  |
| Full name: |  |
| Previous name (if applicable): |  |
| Current address and post code: |  |
| Previous address and post code: |  |
| Date of Birth: |  |
| Hospital number (if known): |  |
| NHS number (if known): |  |

**SECTION 2: Records or information required**

Tick as applicable or provide as much information as possible to enable us to locate the relevant records or information:

Health Records required – tick as applicable:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 🗆 paper records | | 🗆 electronic & paper records | | | | |
| 🗆 electronic records | | 🗆 To view health records (by appt only) | | | | |
| 🗆 Xrays and other images - please state image type: Xray, MRI etc | | | | | | |
| Please indicate which hospital records are required – please give details below: | | | | | | |
| * Hospital/s\* attended: | **CHARING CROSS** | | **HAMMERSMITH** | **QUEEN CHARLOTTES** | **ST MARYS** | **WESTERN EYE** |
| * Date(s) attended: |  | | | | | |
| * Inpatient or Outpatient: |  | | | | | |
| * Consultant/s or health professionals seen: |  | | | | | |

\*PLEASE INDICATE WHICH HOSPITAL/S THE PATIENT HAS ATTENDED

Other personal information – please specify:

|  |  |
| --- | --- |
| Required information: |  |
| Date(s): |  |

**SECTION 3: Declaration (applicant’s details)**

|  |  |
| --- | --- |
| Title: |  |
| Full name: |  |
| Address and post code: |  |
| Telephone number: |  |
| Email address: |  |

I declare that the information given in this form is correct to the best of my knowledge and that I am entitled to apply for access to the health records or other personal information as referred to under the terms of the Access to Health Records Act 1990.

Signature:……………………………………..……………… Date:………………………

Please tick the relevant statements below:

|  |
| --- |
| 🗆 I have been appointed by the court to manage the patient’s affairs and I attach a certified copy of the court order appointing me to do so |
| 🗆 I am the patient’s legally appointed personal representative and I attach proof of my appointment as Executor / Administrator (a sealed Grant of Probate / a Grant of Letters of Administration) |
| 🗆 I have a claim arising from the patient’s death and wish to access information relevant to my claim and attach documentary evidence to support this (solicitor’s letter)  If you are unable to satisfy any of the above, please provide details of why you are submitting an application in order that the Trust can make an informed decision whether voluntary disclosure can be made:  …………………………………………………………………………………………………  …………………………………………………………………………………………………  …………………………………………………………………………………………………  …………………………………………………………………………………………………  ………………………………………………………………………………………………… |
| Signature …………………………………… Date ……………………… |

**Section 4: How would you like to receive the records?**

Please tick the relevant box below:

Secure email: Care Information Exchange: Collection: Post:

**Please return the form by email to imperial.accesstohealthrecords@nhs.net checking that you have:**

Completed all relevant sections

Enclosed your personal identification

Enclosed evidence of your legal right to access the deceased patient’s records or detailed the reason for your application to access the records

Health Records Department

Charing Cross Hospital

Fulham Palace Road

London W6 8RF

Tel: 020 3313 0401 /Email: [imperial.accesstohealthrecords@nhs.net](mailto:imperial.accesstohealthrecords@nhs.net)

PLEASE NOTE THAT APPLICATIONS RELATING TO CHARING CROSS, HAMMERSMITH, QUEEN CHARLOTTE’S & CHELSEA, ST MARY’S AND WESTERN EYE HOSPITALS MUST BE SENT TO THE ABOVE ADDRESS

Revised 03.10.2024