Application for access to your health records under the

General Data Protection Regulation 2018

Please complete using **BLOCK CAPITALS** and provide as much information as possible and 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. **Please therefore provide a copy of your passport, photo driving licence or sufficient equivalent identification**. Two recent utility bills are acceptable.

**Procedure:**

The Trust will aim to provide you with a response regarding the outcome of your application within 1 month of receiving the fully completed request and proof of identity.

Records will be provided electronically via the Care Information Exchange (see section 2), sent via secure email, registered post, or made available for collection free of charge. 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)**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: |  | | | | |
| Surname: | Forename: | | | | |
| Previous name (if applicable): |  | | | | |
| Current address and post code:  Telephone No:  Mobile No:  Email: |  | | | | |
| Previous address and post code: |  | | | | |
| Date of Birth: |  | | | | |
| Hospital number (if known): | NHS number (if known): | | | | |
| Hospital/s attended: | Charing Cross | Hammersmith | Queen Charlottes | St Marys | Western Eye |
| Episodes of Care/Dates required: |  | | | | |
| Consultant/health professional seen: |  | | | | |

Radiology (x-rays, CT scans etc.) – tick as applicable:

|  |  |
| --- | --- |
| 🗆 a copy of all images | |
| 🗆 a copy of specific images only – please give details below: | |
| * Date(s) attended: |  |
| * Type of image – Xray, MRI etc |  |

GDPR – This section **must** be completed in order to process your request:

In order to process your request, the Health Records Team and the Consultant that was looking after your care will need to review the notes before disclosure. Please can you tick the below statement and sign and date, to give consent to this process.

**I give consent for the Health Records Team and the Consultant looking after my care to review my medical file in order to disclose this information to me.**

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

**SECTION 2: How would you like to receive your Records?** Please tick relevant box

Yes No

**Would you like to receive your medical notes electronically?**

The *Care Information Exchange/Patient Knows Best* allows you to view and share your

records electronically. Please note your confirmation e-mail will come from our provider

*Patients Know Best*.

Are you already enrolled on the *Care Information Exchange/Patients Know Best*?

Your identity will already have been validated and therefore you will not be required to provide proof of identity. Please confirm your email address below so that your records can be uploaded:

Email:-…………………………………………………………………………..

Would you like to enrol on the *Care Information Exchange/Patient Knows Best?*

Please provide proof of identity as outlined in this form and confirm your email address below so that your notes can be disclosed electronically to you:

Email: -…………………………………………………………………………………………………….

**Would you like to collect the records?**

We will contact you once they are ready for collection.

**Please be advised 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**

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

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 General Data Protection Regulation 2018 and that:

\*I am the person named on page 1

\*I am acting on behalf of the person named on page 1

\*I am the guardian of the patient who is a child (is incapable of understanding the request) (has consented to my making this request). – see Authorisation section

**(\*Delete as appropriate)**

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

**NOTE**

If you are acting on behalf of another person Part 1 of the Authorisation section below must be completed.

In the case of the patient being a child, Part 2 of the Authorisation section below must also be completed.

**SECTION 4: Authorisation**

Part 1(On behalf of another person)

|  |  |
| --- | --- |
| I hereby authorise Imperial College Healthcare NHS Trust to release any personal information they may hold relating to me to ……………………………………………….. whom I have given consent to act on my behalf. (enter name of the person acting on your behalf) | |
| Signature: | Date: |

Part 2(In the case of the patient being a child, a responsible adult should certify where appropriate that the child understands the nature of the application)

|  |  |
| --- | --- |
| I (name)…………………………………………………Relationship to Patient………….………………………  Of (address) ……………………………………………………………………………………..…………………..  Certify that the applicant understands the nature of this application. | |
| Signature: | Date: |

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

Completed all relevant sections

Enclosed your personal identification (copy of passport/copy of photographic driving licence or 2 x utility bills). If you are acting on behalf of the patient, please also include your identification.

Health Records Department

Charing Cross Hospital

Fulham Palace Rd

London W6 8RF

Email:imperial.accesstohealthrecords@nhs.net

Telephone: 020 3313 0401

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 26.06.2023