

**Access to Health Records Department**

Chancellors Wing

Link Corridor

Leeds Teaching Hospital NHS Trust

Beckett Street Email: [Leedsth-tr.accesstohealth@nhs.net](mailto:Leedsth-tr.accesstohealth@nhs.net)

Leeds Tel: 0113 20 66661/65118

LS9 7TF

**ACCESS TO PERSONAL DATA APPLICATION FORM**

#### ACCESS TO HEALTH RECORDS ACT 1990 / DATA PROTECTION ACT 2018

Data Protection Act 2018 - To access records for a living individual

Access to Health Records Act 1990 - To access records for a deceased patient

Please complete in **BLOCK CAPITALS** and **BLACK INK** if downloading and printing

**Requests for information may include any of the following:**

Health Records

Personal information

Employment records

**Details of the person whose information is being requested**

Mr, Mrs, Miss or Ms: ……………….. DOB: ……………………………………..

Forenames: ………………………….. Surname: ………………………………..

Address: ……………………………… Contact Number: ……………………….

………………………………………….. Previous Surname: …………………….

………………………………………….. Previous Address: ……………………..

Postcode: ……………………………… ……………………………………………

**Applicant’s Details (if different to above)**

Forename: ………………………………….. Surname: …………………………………..

Relationship to Patient: …………………….

Address: ……………………………………..

………………………………………………... Postcode: ……………………………………

………………………………………………... Contact Number: ………………….............

**Please tick box/s below:**

* I am the patient
* I am the employee
* I am acting on behalf of the patient / employee and they have completed the authorisation section
* I am acting on behalf of the patient / employee who is unable to complete the authorisation section for the following reason……………………………………………….
* I am the deceased patient’s next of kin or personal representative
* I have a claim arising from the patient’s death and wish to access information relevant to my claim

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

**Authorisation Section:**

I ………………….. give my authorisation for …………………… (Relation to me) ……………….. to obtain information/copies regarding my medical history / records / information.

**Signature: …………………**

**Is your request in line with the National blood enquiry? Yes/No**

**If your request is for Health Records, please provide details of the Health records you require:**

**Health records dated from \_\_­\_/\_\_\_/\_\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_\_**

Give full details of all the episodes of treatment in which you are interested in, and if you only wish to receive data relating to a special aspect of an episode, please specify in the comments section:

………………………………………………………………………………………………………….

………………………………………………………………………………………………………….

…………………………………………………………………………………………..…………………………………………………………………………………………..…………………………………………………………………………………………..………………………………………………

# Are copies of radiology images required? Yes/No

# Are copies of radiology reports required? Yes/No

Please tick the relevant boxes that apply to your application

X-rays MRI Scan CT Scan MRA Scan Ultrasound Bone Density

**The radiology access department now offers an exclusively online service. In the event that you do not have internet access, please contact us.**

**If your request is for any other information other than health records, please provide details of the information you require below.**

**Information dated from: \_\_\_\_/\_\_\_/\_\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_\_**

Please provide as much information as possible and give full details of any emails, employment records or personal information in which you are interested in below:

…………………………………………………………………………………………………………..

…………………………………………………………………………………………………………..

…………………………………………………………………………………………..………………

…………………………………………………………………………………………………………..

…………………………………………………………………………………………………………..

**Email Address**

Please provide your email address to enable us to send your information electronically

…………………………………………………………………………………………

**Reason For Access** (please tick)

* Complaint/Claim against Hospital
* Personal Use
* Other

Declaration

I declare that the information provided above is correct to the best of my knowledge

For the purposes of identity verification, please select one of the following options;

* Application forms with a physical signature, please attach **one** of the following forms of identification.
* Application forms with an electronic signature, please attach **two** of the following forms of identification.
* Passport
* Driving Licence
* Birth Certificate
* Bus Pass
* Residency/ ID Card
* Death Certificate (when applying for a deceased persons records).
* Health and Wellbeing Power of Attorney documentation.

**Please note**: When applying for medical records on behalf of another individual, identification is required for both parties.