**IN CONFIDENCE**

**REQUEST FOR ACCESS TO MANUAL HEALTH RECORDS**

Complete in **BLOCK CAPITALS**

Particulars of the person whose information is requested

SURNAME ……...FORENAME……SEX……DOB…...

**CURRENT ADDRESS**

……

……
……POSTCODE…….

TELEPHONE

NUMBER…….MOBILE…….

EMAIL……

DIFFERENT NAMES / ADDRESSES IF APPLICABLE:

PREVIOUS SURNAME (1) ……..

(2) ……..

PREVIOUS
ADDRESS……

… ……..

……

APPLICABLE DATES:

……

## PATIENT'S HOSPITAL OR CLINIC CONTACTS

Please provide as much information as possible, giving full details of the episode(s) of treatment that you wish to be made available. **Please also let us know if you need copy notes or copy x-rays/scans by ticking in the appropriate place.**

| Hospital / Clinic attended | Dates | Ward | Consultant | Hospital number |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Copy notes:**

**Copy x-rays/scans:**

**DECLARATION**

I declare that the information given in this form is correct to the best of my knowledge and that:

- I am the person named overleaf
- I am acting on behalf of the person named overleaf
  *(Delete as appropriate)*

NOTE:

- This section of the form must be signed in the presence of the person who countersigns your application.
- If you are acting on behalf of another person, Part 1 of the 'Authorisation' section below must be completed

Applicants name: ……

Applicant's signature…….

Address to which a reply should be sent if different from that specified overleaf

……

……

COUNTER-SIGNATURE (To be completed by the person required to confirm your identity)

This page should be filled in by someone who has known you for at least 2 (two) years, I.e. neighbour, friend or employer/colleague but **not** a member of your family

I (insert full name) ……..

Certify that the applicant (insert name) ……

Has been known to me personally as a (insert in what capacity, e.g.: neighbour, friend, employee etc)

……

and I have witnessed the signing of the Declaration .

Signed ……Date …….

Name ……..Profession ……...

Address ……....

……..

Daytime telephone number……

Mobile……

Email Address…….

**AUTHORISATION**

Part 1: (On behalf of another person)

I hereby authorise NHS Trust to release any Personal Data they may hold relating to me to:

……
*(Enter the name of the person acting on your behalf)*

To whom I have given my consent to act on my behalf

Signed …….

Date ……..