**Request for Information Form**

**incorporating requests made under the General Data Protection Regulation 2016 or the Access to Health Records Act 1990**

*Sections 1, 2, 3 (if appropriate) and 4 of this form must be completed and signed in order for us to process your request.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section 1 Data Subject’s details**  Details of person whose records are being requested | | | | |
| **Surname** | |  | | |
| **Former name** | | (if applicable) | | |
| **First Name** | |  | | |
| **Title** (Mr, Mrs etc.) | |  | | |
| **Date of Birth** | |  | | |
| **NHS Number** | |  | | |
| **Current address** | |  | | |
| **Section 2 Further Information** | | | | |
| **IMPORTANT:** Please use the box below to describe the specific information you wish to see and provide as many details as possible so that we can identify your records quickly. If patient records are being requested, please provide details such as dates, treatments, clinics, hospital, etc.   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | X Ray |  | Oncology |  | Physiotherapy |  | Maternity |  | | A & E |  | ENT |  | Gynaecology |  | Paediatrics |  | | General Surgery |  | Orthopaedics |  | Haematology |  | Maxillo Facial |  | | Ophthalmology |  | Pain Clinic |  | Dermatology |  | Care of the Elderly |  | | Chest Clinic |  | Cardiology |  | Urology |  | General Medicine |  |   Which departments were visited (if known)? Please tick box if not previously referred to. | | | | |
| **Section 3**  **Provision of Information** | | |
| Please confirm the format that you would prefer to receive a copy of the records by ticking the appropriate box | | |
| **Paper copy** | | |
| Paper copy to collect from agreed location | |  |
| Paper copy by post | |  |
|  | | |
| **Section 4 Declaration** | | |
| |  |  | | --- | --- | | **Applying For:** | **Tick as appropriate** | | An individual applying for his/ her own records |  | | Disclosure of records of a deceased person |  | | Person with parental responsibility applying on behalf of a child |  | | Power of Attorney/ Agent applying on behalf of an individual |  | | To view health records |  |   **Please ensure that the relevant identification is included with your application.**  **(Please see guidance sheet)**  Your name (BLOCK CAPITALS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Your address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Your signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The Information you supply for current address etc. may be used by the Trust to update your current name and address  details on our patient computer system in order to help us keep your information up to date. | | |