**Request for Information Form**

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

*All sections of this form must be completed and the relevant evidence provided*

*in order for us to process your request.*

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| **Applicant Details** |
| **Surname** |  |
| **Former name***(if applicable)* |  |
| **First Name** |  |
| **Title** (Mr, Mrs etc.) |  |
| **Date of Birth** |  |
| **Current address** |  |
| **Telephone Number** |  |
| **Email Address** |  |

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| **Patient details***If you are requesting access to another person’s health records please fill in their details below.**Please note: if you are applying on behalf of someone else you will need to provide consent.**If you are applying to access deceased records please ensure you provide the evidence in the box over the page.* |
| **Surname** |  |
| **Former name***(if applicable)* |  |
| **First Name** |  |
| **Title (Mr, Mrs etc.)** |  |
| **Date of Birth** |  |
| **NHS Number** |  |
| **Address** |  |
| **Relationship to applicant** |  |

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| **Required 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.  |
| **Which departments were visited (if known)?** Please tick box if not previously referred to. |
| X Ray |  | Oncology |  | Physiotherapy |  | Maternity |  |
| A & E |  | ENT |  | Gynecology |  | Paediatrics |  |
| General Surgery |  | Orthopaedics |  | Haematology |  | Maxillo Facial |  |
| Ophthalmology |  | Pain Clinic |  | Dermatology |  | Care of the Elderly |  |
| Chest Clinic |  | Cardiology |  | Urology |  | General Medicine |  |

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| **Applying for:*****Please ensure that the relevant identification is included with your application.*** | ***Tick as appropriate*** |
| ***An individual applying for his/ her own records***Two copies of identity required. One form of identification must be photo identification and the other evidence of a recent proof of address. |  |
| ***Disclosure of records of deceased***Two forms of proof of identity (a form of photo ID and a proof of address) and evidence that they are either Executor or evidence of a claim.*Please give a short reason for requesting access & your relationship with the deceased* *(Please note that your request will not be processed without this information):* |  |
| ***Person with parental responsibility applying on behalf of a child****As well as proof of your own identity, please could you provide one of the following documents:** *The child’s birth certificate*
* *Parental responsibility agreement entered into by birth parents; or*
* *Copy of a Court Order giving parental responsibility (such as an adoption order).*

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| *Yes* |  |
| *No* |  |

*Are there any Court Orders or restrictions to access in place?* *If yes, please provide a copy of the order or restriction.* |  |
| ***Power of Attorney****Please provide evidence that you hold power of attorney for health and welfare.* |  |
| ***Applying on behalf of an individual****Please note you will need to provide consent from the individual.* |  |

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| **Format** |
| Please confirm the format that you would prefer to receive a copy of the records by ticking the appropriate box. |
| Paper copy by post |  |
| Paper copy by collection |  |
| Electronic copy*Please note if sent electronically, for example via email, this may not be a secure method and by ticking this you are accepting responsibility.* |  |

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| **Declaration** |
| Please ensure all of the above boxes are complete before signing to confirm the information provided is correct. |
| Signature |  |
| Date |  |

Once complete, please return to: -

By Post: Access to Information Department. Trust Headquarters Lincoln County Hospital, Greetwell Road, Lincoln , LN2 5QY

By Email: ulth.accesstoinformation@nhs.net