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| **Application form for:**  **Subject Access Request**  Under EU & UK Law  And  **Access to Health Records Request**  Under the Access to Health Records (Deceased) Act 1990 |

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| **Please read the Frequently Asked Questions on page 7**  **before completing this form.** |

If you are applying to access the records of more than one person e.g. those of you and your baby or Fertility records which will include your partner’s information, you must complete 2 forms. This will help to prevent delays in your request being processed.

Please tick one box and complete the section stated:

**Are you completing this form to access your own records?**

**Yes please complete section 1**

**No please complete section 3**

**Which Hospital site does your request relate to?**

* **Luton & Dunstable University Hospital**
* **Bedford Hospital**
* **Both**

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| **Section 1** |
| **Please provide us with your details:** Title: (e.g. Mrs/Miss/Mrs)\_\_\_\_\_\_\_\_  Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Number(if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHS Number(if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post code:\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (If applicable)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  We may need to contact you regarding your request, so please provide your telephone number and tick the box if you are happy for us to leave a message.  **Telephone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    You can provide us with your email address if you want to, but we will only use this to contact you if we have been unable to contact you by phone. **Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please provide brief details of why you are requesting a copy of your records:**  (You do not have to tell us, but doing so will assist us in dealing with your request).  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Now complete section 2** |
| **Section 2** |
| **Please tell us what information you are requesting by ticking the boxes below:**   |  | | --- | | **General Health Record** (This record will contain your inpatient and outpatient notes, e.g. notes written by Doctors & Nurses.). There is no need to give us dates for your General Health Record. | | |  |  | | --- | --- | | **Radiology Image Result Reports**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Blood Test Results**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Radiology Images** e.g. X-ray, MRI Scan  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Accident and Emergency Record**  *Date of attendance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Maternity Record**  *Year of pregnancy*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Sexual Health Record** (Your request will be forwarded to Sexual Health Department)  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Physiotherapy Record**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Cardiology Record**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Fertility Record (YOU MUST** include your Partners details and consent by completing a separate form**)**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Intensive Care Unit Record**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Occupational Therapy Record**  *Dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Other** (Please give details):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | | --- | --- | | **Please use the space below to provide us with any additional details about the information you are requesting:**   |  | | --- | |  |   **Now complete section 5** | | | | |

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| **Section 3** |
| **Please provide us with your details:** Title: (e.g. Mrs/Miss/Mrs)\_\_\_\_\_\_\_\_  Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­  We may need to contact you regarding your request, so please provide your telephone number and tick the box if you are happy for us to leave a message.  **Telephone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    You can provide us with your email address if you want to, but we will only use this to contact you if we have been unable to contact you by phone. **Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **What is/was your relationship with the person you are requesting information about?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please provide details of why you are requesting this information & what you are going to do with it:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **If the person you are requesting information about is not deceased or under the age of 16, please provide details of why they are not making the request themselves:**  (Please continue on a separate page if necessary).  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please provide full details of the person you are requesting information about:**  Title: (e.g. Mrs/Miss/Mrs)\_\_\_\_\_\_\_\_\_    Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Number (if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Death (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Full Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (If applicable)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Now complete section 4** |

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| **Section 4** |
| **Please tell us what information you are requesting by ticking the boxes below:**  **General Health Record** (This record will contain your inpatient and outpatient notes, e.g. notes written by Doctors & Nurses).   |  |  | | --- | --- | | Radiology Images e.g. X-ray, MRI Scan | Blood Test Reports | | Radiology Image Result Reports | Accident and Emergency Record | | Maternity Record | Sexual Health Record | | Physiotherapy Record | Occupational Therapy Record | | Fertility Record | Cardiology Record | | Intensive Care Unit Record | Other (Please give details): | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |   **Please provide the approximate date/s this information relates to and if applicable and known, the specialty or consultant they were under:**   |  |  |  |  | | --- | --- | --- | --- | | **Approximate date**  From | **Approximate date**  To | **Specialty** | **Consultant** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Please use the space below to provide us with any additional details about the information you are requesting:**   |  | | --- | |  |   **Now complete section 5** |

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| **Section 5** |
| **To enable us to deal with your request we need you to send us a copy of some documents. These are required for identity purposes.**  Please tick the statement that relates to you and provide a copy of the documents listed.  If none of the following statements apply to you please call **Access to Health Records on 01582 497288 (L&D) or 01234 355122 ext. 5828 (Bedford)** to ask what you should provide, then list them in the space provided at the top of the next page.   |  | | --- | | **I am requesting access to my own information.**  Please provide a **copy** of:   * Your passport or driving licence or something with your signature on   And   * A utility bill or financial statement that has your name and address on   (If possible, please black out any financial information) | | **I am requesting access to information about a person who is under the age of 16 who I have parental responsibility for.**  Please provide a **copy** of:   * Their Birth Certificate or Adoption Certificate or proof of custody/responsibility   And   * Yourpassport or driving licence or something with your signature on   And   * A utility bill or financial statement that has your name and address on   (If possible, please black out any financial information) | | **I am requesting access to information about a person for who I have Power of Attorney or a Court Order of Protection.**  Please provide a **copy** of:   * A copy of the signed Power of Attorney document   And   * Their passport or driving licence or a an official document with their photograph on   And   * A utility bill or financial statement that has their name and address on   (If possible, please black out any financial information)  And   * Your passport or driving licence or something with your signature on   And   * A utility bill or financial statement that has your name and address on   (If possible please black out any financial information) | | **I am requesting access to information about a deceased person for who I am Executor of their Estate or Administrator of their Will.**  Please provide a **copy** of:   * An official document or letter which lists you as the Executor of their Estate or Administrator of the Will   And   * Your passport or driving licence   And   * A utility bill or financial statement that has your name and address on   (If possible, please black out any financial information). |   **….continued on next page…**  **… continued from previous page…**  **None of the statements above apply to my request. I have contacted the Access to Health Records team and I am providing the following as instructed by them:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Now please sign in section 6** |

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| **Section 6** |
| **WARNING:** Making a false or misleading request in order to obtain access to personal information is a criminal offence.  By signing below you are confirming:   * That the information given on this form is correct. * That the copy documents being provided are true copies of genuine originals. * That you have read the Frequently Asked Questions on the next page and understand that accessing a copy of these records may incur a charge. (An invoice will be sent to the requester of the information).   **Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **Please return your completed form and the copy documents requested in section 5 to:**  **Information Governance Department Access to Health Records  Luton & Dunstable University Hospital**  **Bedfordshire Hospitals NHS Foundation Trust**  **Lewsey Road Luton LU4 0DZ**  [**accesstohealthrecords@ldh.nhs.uk**](mailto:accesstohealthrecords@ldh.nhs.uk)  **OR**  **Information Governance Department**  **Access to Health Records Bedford Hospital**  **Bedfordshire Hospitals NHS Foundation Trust**  **Kempston Road Bedford MK42 9DJ**  [**subjectaccess@bedfordhospital.nhs.uk**](mailto:subjectaccess@bedfordhospital.nhs.uk) |   **Please note:** The copies of the documents you provide us with will be used in the processing of your request. They will be retained for 3 months after your request has been finalised, then destroyed on site by crosscut shredding. |

**Frequently Asked Questions:**

**Question: Do I have a right to be provided with a copy of my Health Records?**

**Answer:** Yes, under the EU and UK Law you have this right. Your request MUST be made in writing. You can do this by completing the attached form, which once completed and returned to us will give us the information we need to deal with your request.

**Question: Do I have to explain why I want a copy of my records?**

**Answer:** No, you do not have to, however, giving us a brief explanation of why you want them will assist us in dealing with your request.

**Question: Do I have the right to be provided with a copy of another individuals Health Record?**

**Answer:** Only if the individual you are requesting the records about is under the age of 16 and you have legal parental responsibility for them or you have been appointed by the court to manage that individuals affairs when they are unable to e.g. power of attorney. You will need to tell us why you want the records.

**Question: Do I have the right to a copy of a deceased persons Health Record?**

**Answer:** The Access to Health Records Act 1990 provides certain individuals with a right of access to the health record of a deceased individual. These include the executor or administrator of the deceased person’s estate/will and a person who may have a claim arising out of the individual’s death. These requests will be assessed on a case by case bases.

**Question: How long will it take for me to be provided with the records I request?**

**Answer:** Under the EU and UK Law we are required to provide you with the records within **one calendar month** and under the Access to Health Records Act 1990 within 21 days. Where possible we aim to provide all requested records within 21 days or sooner.

**Question: Will I have to provide any identification?**

**Answer:** Yes. You MUST send us copies of the documents listed on Section 5 of the form. Failure to send these will result in your request NOT being processed.

**Question: How will I receive the records?**

**Answer:** This will depend on what information you are requesting. Most of the records we hold are now held electronically, so you may be provided with a disc. Records which cannot be provided on a disc will be sent to you in paper format.

**Question: Will I have to pay?**

**Answer:** No, there will be no charge.

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| If you have any further questions or need assistance please contact:  Access to Health Records on **01582 497288 (L&D) or 01234 355122 ext. 5828 (Bedford)** |

**Please keep this page for reference or in case you need to contact us.**