

**APPLICATION FOR ACCESS TO HEALTH RECORDS**  
**DATA PROTECTION ACT 1998**

Did you know that you can make a *formal* request to see your health records, or those of your child or relative? Of course, this does not stop you from asking to see the health records *informally* when you see the doctor, although he/she may refuse a request on various grounds.

In order to maintain the maximum confidentiality of the patient, only those people authorised will have access to the health records and any viewing will be supervised. Alternatively, you can request that a copy of the records be sent to you. There is usually a fee payable for this service (please refer to the covering letter).

**HOW TO MAKE A FORMAL REQUEST**

Please complete the relevant sections of this form (see table below) and send it to the *Patient Information Officer* at the above address. All requests for access to medical records must be in writing.

When we receive the form, we will send you an acknowledgement and a formal reply will follow within 40 days.

**COMPLETING THIS FORM**

WHOSE RECORDS ARE YOU REQUESTING?	COMPLETE SECTIONS:
Your own	1, 2, 3, 6
A friend / relatives / colleague (16 years+)*	1, 2, 3, 4, 6
A child (under 16 years)*	1, 2, 3, 5, 6

*\*If the patient is deceased, you cannot apply using these forms.*

## SECTION 1 – PATIENT'S DETAILS – AT THE TIME OF TREATMENT

Last name (Surname): ....Bullen..... Hospital number (if known): ..M63../1420  
First name(s): ...Paul...Thomas... Date of Birth: ... GRO-C 58.....  
Address: ..... GRO-C .....  
..... GRO-C ...Cheshire.....  
Postcode: ... GRO-C ..... Telephone No.: ... GRO-C .....

## SECTION 2 – WHICH RECORDS ARE REQUIRED?

### RECORD IN RESPECT OF TREATMENT FOR:

Date Attended	Hospital	MRI	Consultant (if known)
1963 –	All medical documentation	including all	Dr. Hay
treatment	data material	from 1963 to	
	the present day.		

## SECTION 3 – TO BE COMPLETED BY ALL APPLICANTS

*I DECLARE that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health record referred to under the terms of the Data Protection Act 1998.*

Last name (Surname): ...Bullen..... First name(s): ...Paul...Thomas..  
Current Address: ..... GRO-C .....  
..... GRO-C ...Cheshire... Postcode: ... GRO-C ..  
Telephone No: ... GRO-C ..... Signature of Applicant: ... GRO-C .....

Tick as appropriate

- ☒ I am the patient – go to Section 6
- ☐ I have been asked to act by the patient who has given written consent below – go to Section 4
- ☐ I am the parent / guardian of the patient who is under the age of 16 – go to Section 5

## SECTION 4 – TO BE COMPLETED IF YOU ARE APPLYING FOR RECORDS ON BEHALF OF ANOTHER (16 YEARS + OVER)

Please state your relationship to the patient: .....

This part to be completed by the patient:

*I confirm that I have no objection to my records being viewed by the applicant.*

Signature of Patient: ..... Date: .....

## SECTION 5 – TO BE COMPLETED IF YOU WISH TO VIEW THE RECORDS

(A) Please state your relationship to the child: .....

(B) What is your current status: (please tick a box)

- ☐ Married + living together
- ☐ Married + living apart
- ☐ Officially separated
- ☐ Divorced
- ☐ Single and living together
- ☐ Single
- ☐ Widowed

(C) Who has legal parental responsibility for the child? (please tick a box)

- ☐ You have sole responsibility
- ☐ Your partner has sole responsibility
- ☐ You both have joint responsibility
- ☐ Other – (*please specify*): .....

(D) Please give the full name and address of the person(s) indicated in question 5C above

Address 1: .....

.....

Address 2: .....

.....

Address 3: .....

.....

*Note: Before a request to view the health records of a child can be granted, written consent must be sought from ALL those persons who hold legal parental responsibility. Failure to obtain consent means that the application will be refused.*

**SECTION 6 – TO BE COMPLETED BY A PERSONAL FRIEND,  
EMPLOYER OR OTHER PROFESSIONAL**

*I certify that the applicant named above is known to me and that I have known them for  
...3.2... years as an employee(friend/patient/client) (please circle as appropriate)*

Name of Witness: GRO-C .....

Signature of Witness: ..... GRO-C ... Date: ...2.5/1/04.....

**SECTION 7 - TO BE COMPLETED BY THE PATIENT INFORMATION OFFICER**

For the attention of: Dr. Hay - Haem

**DATA PROTECTION ACT 1998**

An application has been made under the above Act for access to the health records of:

Name: Paul Bullen Hospital No: M63/1420

The request has been made by:

- ☒ The person named above  
☐ On behalf of the person named above (with consent)  
☐ On behalf of the person named above (without consent)

Access has been requested to view the records in respect of treatment for:

Condition: All Haem Notes Dates: From 63 to present

Please review these notes and let me know prior to ASDP, by completing this form, whether you agree to this request. The notes, together with this completed form, should then be returned to the ~~Patient Information Officer~~ who is responsible for contacting the applicant.

BETTY GLEESON, OUTPATIENT HALL, MRI.

**SECTION 8 - TO BE COMPLETED BY THE HEALTH PROFESSIONAL**

☒ I agree to UNLIMITED access to the above notes by the applicant.

☐ I agree to LIMITED access to the above notes because: .....

- .....  
♦ Copy enclosed to be sent to the applicant  
♦ Partial inspection of data from ...../...../..... to ...../...../..... only.

☐ I DO NOT AGREE to this request because:

- ♦ It would cause serious mental or physical harm to the patient  
♦ It would identify another patient/someone unrelated to the treatment given  
♦ It is not in accordance with the best interests/know intentions of the patient

Signature: ..... **GRO-C** .....

Name (Block Capitals Please) E. Hay

Designation: front desk Date: 29.1.04

♦ Please delete as appropriate

AHRDP/August 2000