**REQUEST FORM FOR MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON**

Please complete using black pen and **BLOCK CAPITALS**.

**SECTION 1: Recipient’s details**

Please send this form to the appropriate healthcare facility and provide the following details on the front of the envelope:

|  |
| --- |
| **For records held by a GP:** To the Practice Manager, GP’s name and surgery address OR**For records held by a hospital or healthcare provider:** To the Records Manager, hospital name and hospital addressOR**If the individual is not registered with a GP:** to the Records Manager at the relevant service provider (addresses provided in the Guidance on requesting medical records document on the Inquiry website) |
|  |

**SECTION 2: Patient’s details**

|  |  |
| --- | --- |
| Surname |  |
| Forename(s) |  |
| Former name(s) (if applicable) |  |
| Date of Birth |  |
| NHS Number (if known) |  |
| Current Address (including postcode) |  |
| Previous Address/es (if applicable / including the dates that they moved) |  |
| Telephone Number |  |
| Contact Email (optional) |  |

**SECTION 3: Identity of individual requesting information**

|  |  |
| --- | --- |
| Surname |  |
| Forename(s) |  |
| Relationship to Patient |  |
| Current Address (including postcode) |  |
| Telephone Number |  |
| Contact Email (optional) |  |

**SECTION 4** – **Details of the medical record(s) that you wish to request a hard copy of:**

|  |  |
| --- | --- |
| All or part of the records that are held (please specify) |  |
| If you would like to only request part of a record, please state the date range |  |
| Name of GP surgery, hospital or other healthcare provider |  |
| Service/treatment received |  |
| Approximate date(s) that the treatment was received |  |
| Name of Doctor / Consultant / Healthcare Professional seen (if known) |  |
| Please provide any further details to help clarify the information that you are requesting  |  |

**SECTION 5: Waiver of fees for the purpose of providing evidence to the Infected Blood Inquiry**

Under the General Data Protection Regulation that came into force on the 25 May 2018 an organisation cannot usually charge a fee for a personal data request.

In any event the Chief Executives of NHS England, Wales, Scotland and Northern Ireland have confirmed that all fees that would normally be charged to access and obtain copies of medical records will be waived for those witnesses that are providing evidence to the Inquiry. Copies of the letters to the NHS Chief Executives and their responses can be viewed on the Inquiry’s website: [https://www.infectedbloodinquiry.org.uk/](https://www.infectedbloodinquiry.org.uk/#https://www.infectedbloodinquiry.org.uk/).

**SECTION 6: Proof of identity (Patient’s)**

**I have included photocopies of the following identification documents:**

* One form of photographic personal ID

**AND**

* One proof of current home address

Acceptable forms of identification documents include: passports, photo driving licences, bank statements and utility bills, but not mobile telephone bills, as they can be sent to different addresses.

**SECTION 7: Declaration by applicant**

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 2018.

Please tick one of the following:

I have been asked to act by the patient and attach the patient’s written authorisation (the patient has signed the patient authorisation section below and has provided a copy of photographic ID as proof).

OR

I have been appointed by the court to manage the affairs of the patient and attach confirmation of my appointment (Power of Attorney).

**Print Your Name:………………………………………………………………**

**Your Signature:…………………………………………………………………….**

**Date:………………………………………………………………………………….**

**Section 8: Patient authorisation**

I hereby authorise the release of any health records relating to me

to……………………………………………………………………………………….,

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

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

**Signature of Patient ………………………………………………………………..**

**Date…………………………………………………………………………………….**