

Application for access to health records held by the University Hospitals of Leicester NHS Trust

Please read the information sheet before completing this form

Part A – Identity of the patient about whom the information is requested:

PATIENT'S DETAILS (records to be accessed)	
Patient's title (Mr/Mrs/Miss)	
Patient's full name	
Date of Birth	
Address Postcode	
Telephone number	
Hospital no (if known)	
Email address (so we can send you a password)	

Part B – Details of the information required:

RECORDS REQUIRED	
Details of records required please be as specific as possible e.g. department attended, consultant's name	
Dates of records required e.g. accident date	
Hospital records required	Leicester Royal Infirmary Leicester General Hospital Glenfield Hospital (delete as appropriate)
I wish to:	<input type="checkbox"/> Have photocopies of the records (please note there will be a charge for the recorded delivery) <input type="checkbox"/> Have a copy of the records on CD
Do you require copies of x-rays?	YES/NO (delete as appropriate)

Part C – Applicant details and declaration:

APPLICANT'S DETAILS (if different from the patient)	
Full name (including title)	
Address Postcode	
Telephone number	
Relationship to patient	

DECLARATION (please tick one of the following boxes):	
I am the patient	
I have been authorised to act by the patient	
I am the patients parent/legal guardian and have parental responsibility	
The patient is over 13 years of age. I am their next of kin/legal representative. I am making this application as they lack the capacity of understanding to make the request themselves and I attach a copy of the authority enabling me to do so e.g Lasting power of attorney	
I have been appointed by the court to manage the patient's affairs and I attach a certified copy of the court order appointing me to do so	
I have a claim arising from the patient's death and wish to access information relevant to my claim	

Please confirm the details of the identification information enclosed with this application:

Enter Y or N

	Photocopy of current photo driving licence
	Photocopy of current passport
	Authorisation to act on behalf of a person that lacks capacity
	Other confirmation such as a list of medications, medical diagnosis, last consultation data etc
	Confirmation the applicant is the personal representative if the patient is deceased

I declare that the information given is correct to the best of my knowledge and that I am entitled to apply for access to the information detailed above under the terms of the General Data Protection Regulation (GDPR) 2016 or the Access to Health Records Act 1990 (ATHRA)

APPLICANT'S SIGNATURE: DATE:

Part D – Authorisation for application made on behalf of another person:

I hereby authorise release of my records, as specified above, to the person named in part C and declare that I am the person named in Part A of this form.

Print Name:	Signature:
Date:	

Before returning this form please ensure that you have:

- a) signed and dated this form
- b) completed all relevant sections
- b) enclosed proof of your identity
- c) enclosed the correct fee (if applicable)
- d) enclosed documentation to support your request (if applying for another person's records)

WARNING - You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Please send the completed form and documentation to:

Access to Health Records
Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Tel No: 0300 3031563 (option 3)
Fax No: 0116 2047925
Email: ahlri@uhl-tr.nhs.uk