Hounslow and Richmond Community Healthcare NHS Trust

AUTHORITY FOR RELEASE OF PERSONAL RECORDS

(Subject Access Request under the GDPR / Access to Health Records Act 1990)

Please complete all sides of this form and return it to the address overleaf together with proof of identity and other relevant information. The making of untrue statements to secure access to personal information to which you are not entitled is a criminal offence.

We action all requests as quickly as possible but please be aware that it may take up to 30 days to compile and copy all the information required.

SECTION 1 - DETAILS OF APPLICANT (whose records are being requested):
Surname:
Former Surname: (if applicable)
First Name:
Title:
Date of Birth:
NHS Number:
Current Address:
Postcode:
Former Address: (if applicable)
Postcode:
Email:
Telephone Number:

SECTION 2 - DETAILS OF REQUESTOR (if making a request on behalf of the applicant above):
Name:
Address:
Email:
Relationship to person in Section 1:

SECTION 3 – DETAILS OF TREATMENT: **Give details of the information you require**			
Date attended	**Service/Clinic**	**Consultant**	**Hospital Number (if known)**

FURTHER INFORMATION - IMPORTANT
Please 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. If staff records are being requested, please indicate whether the staff member still works for the Trust and provide the payroll number if known.
Information requested if not specific to a certain appointment:

SECTION 4 - PROVISION OF INFORMATION:
Please note that our usual method of providing access to records is to post copies to your stated address. If you wish to access records by any other means please indicate below. We will then contact you in order to facilitate this.
Viewing/Collect records at a Trust location:
Email: I confirm that I am happy for a copy of my information to be sent to the email address listed below: Email address:
Other (please specify):
SECTION 5 – DECLARATION OF CONSENT:
I confirm that I am the person named in Section 1 and that I require access to my personal records: **Yes / No**
I confirm that I am the person named in Section 1 and I authorise the release of copies of my personal records to the person named in Section 2: **Yes / No**
I confirm that I am the person named in section 2 and I have parental responsibility for the child named in Section 1 (of Child is under 13): **Yes / No**
I confirm that I am the person named in Section 2 and have been authorised to act as an agent/power of attorney for the person named in Section 1: **Yes / No**
Signature:
Print Name:
Date:
SECTION 6 – EVIDENCE:
Photographic evidence is needed to prove the identity of the applicant i.e. a copy of a passport or driver's licence. Please note the evidence provided below. If you are acting on behalf of a named person, please include evidence such as a copy of the LPOA documentation
Please return this form and copies of identification to:
Information Governance Team **Hounslow and Richmond Community Healthcare** **Heart of Hounslow Centre for Health** **92 Bath Road, Hounslow, TW3 3EL** **Or email:** hrch.informationgovernance@nhs.net
NB Please mark the envelope as 'Private and Confidential'. Please keep a copy of this form.