Western Health and Social Care Trust

For Office Use Only
ID received:
Consent / Legal Docs received:

Request for Access to Patient / Client Records Form

General Data Protection Regulation / Access to Health Records (NI Order) 1993

Please complete application form in BLOCK CAPITALS and BLACK PEN

I am requesting access to (please tick as appropriate) :-

1. my own personal record. Please complete sections **A, C, D & F** ☐
2. records belonging to another living individual. Please complete sections **A, B, C, D & F** ☐
3. records of a deceased person. Please complete sections **A, B, C, E & F** ☐

Please Note

- Access to personal information is provided free of charge. However, the Trust reserves the right to charge a fee or to refuse to respond to a request that is manifestly unfounded or excessive. For this reason please ensure your request for information is as concise and focused as possible. We will contact you if we require further details about your request.
- Repeat requests for information already provided will only be processed in exceptional circumstances. The Trust reserves the right to charge a fee for a repeat request.
- The General Data Protection Regulation (GDPR) allows up to 90 days for providing a response to complex requests. Please note that as requests for medical and social work records require review by a clinical / social care professional the majority of requests will be deemed to be complex and will take up to 90 days to respond to. Requests that are not deemed to be complex will be responded to within 30 days.

  For access to deceased patient records the Access to Health Records (NI) Order 1993 allows up to 40 days to respond to a request, or 21 days where the requested records have been created within the last 40 days of the date of the request.

SECTION A – Details of the person the records / information relates to:

Surname:		**First name(s)**	
Date of Birth:		**Former name:**	
Current Address:			
Post Code:		**Tel. Number:**	
Any Previous address:			
Hospital / Healthcare Number (if known):			

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SECTION B – **Details of the person requesting the records** *(if different from section A above)*

Surname:		**Forename(s):**	
Applicant's Address:			
Post Code:		**Tel. Number:**	
Relationship to the named Patient / Client:			

SECTION C – **Details of the record(s) you wish to access**

Name of hospital, ward, clinic or community service:	
Type of Service Received:	
Date(s) of treatment or service provided (i.e. from / to)	
Doctor / Health Professional / staff seen (if known):	

SECTION D – ***Authorisation and Identification.***

Please Note acceptable forms of proof of identity are for example a copy of your passport, driving licence, Translink Senior Citizen Smart Pass, electoral card, birth certificate or medical card.

Please select 1, 2, 3 or 4 from the following options; (if 4, please also select further criteria)

☐ **1) I am the patient** and enclose proof of my identity (copy or original ID documents)

☐ **2) I have parental responsibility** however the child **is capable** of understanding this request and I attach their written consent allowing me to access their personal information on their behalf

☐ **3) I have parental responsibility** and the child named above **is NOT capable** of understanding this request or consenting to the release of his/her records. I am acting in his/her best interests.

☐ **4) I am acting as an advocate on the patient's / client's behalf** and **confirm that either**:

- ☐ The patient / client is capable of understanding this request and has asked that I act on their behalf. Their written signed consent is enclosed along with a copy of ID for myself and for the patient/client

- ☐ The patient/client is NOT capable of understanding the request. I confirm that I am acting on their behalf and in their best interests. I understand that capacity will be checked with relevant health / social work professional(s) and records will only be disclosed if, in the opinion of the relevant professional, it is in the patient's / clients best interests. If approved, I understand that any access provided will be limited to information that will meet the needs of the patient/client.

SECTION E – **Requesting Access to the Records of a Deceased Person** – Access is only granted to individuals who are the personal representative of the deceased or individuals who may have a claim resulting from the death of the patient / client and where evidence of entitlement is provided. Only information relevant to the claim will be considered for disclosure. A view will be sought from health and social care professionals.

Date of Patient / Client Death ______________________________

Please select from the following options;

1) I am the personal representative of the deceased patient / client and enclose documents confirming my role as personal representative e.g. Grant of Probate / Letters of Administration. I also enclose proof of my identity ☐

2) I am the personal representative of the deceased patient / client and include evidence of this from a solicitor or court office. I also enclose proof of my identity ☐

3) I have enclosed documentation from a solicitor detailing the claim I may have arising out of the patient /clients death and I also enclose proof of my identity ☐

SECTION F – DECLARATION

- 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 records / information referred to under the terms of Data Protection legislation / Access to Health Records (NI) Order 1993
- I understand that applications received without the necessary ID / consent / legal documentation will not be processed and will be returned
- I understand that the Western Health & Social Care Trust is no longer responsible for the security and confidentiality of any Health& Social Care records which have been photocopied and supplied to me

Applicant's signature:________________________________ **Date:**_________________________

Return the completed and signed subject access form along with supporting documents to:

Information Governance Office;
Main Building;
Tyrone & Fermanagh Hospital;
1 Donaghanie Road;
Omagh;
Co. Tyrone;
BT79 0NS

Enquiries to: Tel: 028 8283 5440
Email: Information.Governance@westerntrust.hscni.net

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