East and North Hertfordshire NHS
NHS Trust

APPLICATION FOR ACCESS TO HEALTH RECORDS – RADIOLOGY IMAGES

LAST NAME:	FIRST NAME:
DATE OF BIRTH:	GENDER:
NHS NUMBER:	HOSPITAL NUMBER:
ADDRESS:	
PHONE NUMBER:	

I REQUEST COPIES OF THE FOLLOWING IMAGES ON CD

RADIOLOGY IMAGE(S) (BODY PART)	
DATE (APPROX)	

- ☐ I WILL COLLECT DISC FROM THE RADIOLOGY RECEPTION AT THE **LISTER HOSPTAL**
- ☐ I REQUEST THAT THE DISC BE SENT TO THE ABOVE ADDRESS
- ☐ 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 records referred to the above under the terms of the **Access to Health Records Act 1990** and the **Data Protection Act 2018.**
- ☐ I am the Patient.
- ☐ I have been asked to act by the patient and I attach the patient's hand written authorisation.
- ☐ I am acting in loco parentis as the patient is under the age of 16.
- ☐ I am the deceased patients' personal representative and attach conformation of my appointment
- ☐ I have a claim arising from the patient's death and wish to access information relevant to me on the grounds that:_____

SIGNATURE:	DATE:
NAME & ADDRESS IF DIFFERENT FROM ABOVE:	
RELATIONSHIP TO PATIENT:	

Please send form to;
RADIOLOGY DEPARTMENT, LISTER HOSPITAL, COREY'S MILL LANE, STEVENAGE, SG1 4AB

This Disc can only be viewed using **Microsoft Windows XP or later.**

Under GDPR guidelines, your request will be processed within 30 calendar days.