East and North Hertfordshire NHS
NHS Trust

Radiology
Lister Hospital
Corey's Mill Lane
Stevenage
Herts
SG1 4AB

Radiologylegal.enh-tr@nhs.net

Tel: 01438 285907

SUBJECT ACCESS REQUEST

In order to access copies of medical records please complete the attached application form.

Please ensure all parts of the form are completed. **We cannot accept your application without all of the following requirements**:

- The form is signed (we do not accept electronic signatures)
- The certification page needs to be completed by someone that knows you to confirm the identity of the requestor
- You must provide photographic identification e.g. a copy of a valid passport or driving licence
- The correct declaration box is ticked:
    - If acting on behalf of the patient, we also require written permission from the patient or Power of Attorney
    - If applying for a child's records we will require a copy of the full birth certificate to show parental responsibility
    - If the child is 13 years old or above they are also required to sign the form giving their consent to the request

Under the General data Protection Regulations 2018, once we have received all requirements, we have 30 days to provide the records.

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Patient Consent form

SUBJECT ACCESS REQUEST FORM

(Data Protection Act 1998 & General Data Protection Regulations 2018)

Details of the Patient whose records are to be accessed

Surname: _____ Forename(s): _____

Current Address: _____

_____ Post Code: _____

Telephone Number: _____

Gender: _____ Date of Birth: _____ Hospital No: _____

If your name or address was different from the above during the period(s) to which your application relates please provide details below:-

Previous Name: _____

Address: _____ Post Code: _____

Details required

Type of scan e.g. X-Ray, CT, MRI, US _____

_____

Approximate date _____

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 Health Record referred to above under the terms of the GDPR 2018 **(please tick one of the following)**

I am the patient ……. ☐
I have been asked to act by the patient and attach the patient's written permission …… ☐
I am acting in *loco parentis* and the patient is:
(i) Under 13 years of age …….. ☐
(ii) Over 13 years of age and has consented to this request…….. ☐

(Full Birth certificate required)

FULL NAME: _____ **SIGNED:** _____

DATE: _____ **SIGNED (CHILD OVER 13)**_____

ADDRESS IF DIFFERENT FROM ABOVE: _____

_____

Email Address: _____ Telephone/mobile number: _____

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PLEASE ENSURE VALID PHOTOGRAPHIC IDENTIFICATION OF THE APPLICANT IS PROVIDED
E.g. Passport or Driving Licence

CERTIFICATION

to be completed by the person confirming the Applicant's identity

I hereby certify that I am (Name) _____

Of (Address) _____

_____

and that I have known the Applicant for _____ years as: _____

(State in what capacity e.g. employee, client, patient, personal friend)

SIGNED ……

DATE …….....

Fees

- **A copy of your information is free of charge**
- **A charge may be applied if the request is manifestly unfounded or excessive**
- **All charges will apply again if the request is repetitive.**

WHERE FEES APPLY THE FEE MUST BE PAID BEFORE ANY COPIES OF THE RECORDS CAN BE DISPATCHED

Preferred method of receipt of information: * **Please circle or highlight preferred method.**

Collect from Radiology at Lister Hospital / Royal Mail Signed For

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For Official Use only by the Clinical IT Team

Date form received: _____

Certification completed Yes / No

Photographic identification received Yes / No

Birth certificate / patient consent received (if applicable) Yes / No

Date for Day 30:_____

Date Completed: _____