Royal United Hospitals Bath NHS
NHS Foundation Trust

APPLICATION FOR ACCESS TO HEALTH RECORDS (Form SAR 1)

This form has 7 sections

Please complete **Sections 1, 2, 3 4 and 5**

Sections 6 and 7 are to be completed if applicable.

All Sections are to be completed in CAPITAL LETTERS.

Please provide as much information as possible which may be of assistance to the Trust in processing your request.

Incomplete forms will be returned which may in turn delay the processing of your request. Please refer to the separate information sheet **'Information for Applicants'** in completing this form.

<table>
<tr><th colspan="2">Section 1 – Personal details</th></tr>
<tr><td>1. Full Name of Patient
(Mr/Mrs/Miss/Ms)

Surname

Forename</td><td rowspan="3">5. Any Former Address</td></tr>
<tr><td>Any previous name(s)</td><td>6. NHS/ Hospital Number (if known)</td></tr>
<tr><td>2. Date of Birth (dd/mm/yy)</td><td>7. Surname and Forename of applicant if different from the patient. (patient authorisation must be provided in Section 5)</td></tr>
<tr><td>3. Contact Telephone Number</td><td rowspan="2">8. Address to which reply should be sent (if different from that of patient)</td></tr>
<tr><td>4. Current Address (inc postcode)</td></tr>
</table>

Section 2a – Details of the record to be accessed

Please use this form to request multiple or single document types *e.g. if you require copies of the Maternity Record and Main Health Records*; please do not submit separate forms for each request.

Please complete **Step 1** and **Step 2 below**

Step 1 ; Please circle which Record Type(s) you require copies of-:

Medical Record **A&E (ED) Record** **Radiology Images** **Physiotherapy Record** **Maternity Record**

Step 2 ; Please provide details of the episode/parts of your health records you require copies of using the table below:

Ward/Clinic attended (with dates):	Consultant (s) (if known):

Please use the space below to provide us with any additional information in order to meet your request to access your health record (attach additional information if necessary

I have attached additional information ☐

Section 2b: Viewing your Records

If you wish to **View your Records** only, please complete **step 2** and indicate below - you will then be contacted to make an appointment. ☐

Section 2c: Requesting Radiology images

If you have requested copies of your imaging performed at the Royal United Hospitals, we will send this to you electronically using a system called IEP (Image Exchange Portal.)

In order for us to do this, we require an email address and a UK mobile phone number.

A link to access your images will be sent to the email address provided below and a password to access these images will be sent with a SMS message to the UK mobile phone number. If you don't have a UK Mobile phone number, we can send the password to a secondary email address.

Email Address	
UK Mobile Phone Number or Secondary Email	

Please be aware that if you have requested copies of your health records in addition to Radiology images, the copies of your Records will be sent separately.

In order to process your request, two types of identification will be required **from the applicant** (person receiving the information) one of which must contain your current address e.g. Utility Bill.

Section 3 – Identification

What identification has been included as part of the application. Please do not provide originals.

Passport	☐	Birth Certificate	☐
Driving Licence	☐	Other (e.g. utility Bill)	☐

Section 4 – 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 General Data Protection Regulations (2018) and/or Access to Health Records Act (1990).

Please tick **one** of the following boxes:

I am the patient (complete Section 5 below) ☐	I have been appointed the Guardian for the patient , who is over age 16 under a Guardianship order. (Complete Section 5 below) ☐
I have been asked to act by the patient (Complete Section 6 below). ☐	**Access to Records of the Deceased** I am the deceased patient's personal representative and attach confirmation of my appointment (complete section 5 below) evidenced via a FULL copy of the **Deceased persons Will and / or a Grant of Probate**. *(Please note in some cases a copy of the Will on its own will not be sufficient)* ☐
I have parental responsibility/legal guardianship for the patient who is under 13 years of age (complete Section 5 below) ☐ **For access to records of children or young person aged 13 years to 16 years the child is required to provide consent**. (Complete section 7 below together with the child's authorisation) - *See information for applicants guidance* ☐	**Access to Records of the Deceased** I have a claim arising from the patient's death and wish to access information relevant to my claim – the information will support my claim for the following reasons as well as being evidenced via a **FULL copy of the Deceased persons Will and / or a Grant of Probate**. *(please note in some cases a copy of the Will on its own will not be sufficient)* (complete section 5 below) ☐ : …… …… *(attach additional information if necessary)*
I have Lasting Power of Attorney for the patient (please attach LPA documentation and complete Section 5 below) ☐	

Section 5: Authorisation

I have read the 'Information for Applicants' information sheet and authorise a request to access health records to be carried out. **I enclose two forms of identification.**

Applicant's Signtaure_____Date:_____

Section 6: Authorisation (to be completed only when applicant is acting on behalf of another person)

I_____(print name) hereby authorise the Royal United Hospitals Bath NHS Foundation Trust to release any personal health records it may hold relating to me to_____(insert name of person acting on your behalf) to whom I have given consent to act on my behalf.

Signed:_____ Date:_____

Section 7: Authorisation (to be completed only in the case of a child aged 13 to 16 years – see section 4)

I _____ (name of applicant)

of_____ (insert address) certify that the patient (Child) understands the nature of this application and has consented to the release.

Signed: (Applicant) _____

Date:_____

Signed : Child or young person's signature _____

Date:_____

Completed Forms:

Completed forms should be sent to:

Via email with attachments to: ruh-tr.medicalrecordenquiries@nhs.net

Or sent via post to-:
Medical Records Department
Health Informatics Service
Apley House (E5)
Royal United Hospitals Bath NHS Foundation Trust
Combe Park
BATH
BA1 3NG