**Form for Subject Access Request under the Data Protection Act 2018**

**or Access to Health Records Act 1990**

*It is not essential to complete this form for us to process your request, but if you choose to use the form, it would help us to avoid delay in processing your request if all fields are fully completed.*

**Please note: The University Hospital Southampton NHS Foundation Trust are only able to process requests for access to any personal data that we hold for you. Requests for access to primary care health records (General Practice) or Hospital or Community services, (secondary care), should be directed to the organisation that provided your treatment/care.**

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| **Section 1** **Details of the person whose records are being requested** | | | | | | | |
| **Surname** |  | | | **Previous name**  *(if applicable)* | |  | |
| **Forename(s)** |  | | | | | | |
| **Title** *(please circle)* | Mr | | Mrs | Miss | Ms | | Do not wish to say |
| **Date of Birth** |  | | | | | | |
| **NHS Number**  *(if known)* |  | | | **Hospital number**  *(if known)* | |  | |
| **Current Address** | | | | **Previous Address** | | | |
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| **Contact number (s)** | |  | | | | | |
| **Email address** | |  | | | | | |
| **If you are the patient please go straight to section 3** | | | | | | | |

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| **Section 2** **Details of the applicant (if different from the patient)** | | | | | | | | | |
| **Surname** |  | | | **Previous name**  *(if applicable)* | | | |  | |
| **Forename(s)** |  | | | | | | | | |
| **Title** *(please circle)* | Mr | | Mrs | | | Miss | Ms | | Do not wish to say |
| **Current Address** | | | | | **Previous Address** | | | | |
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| **Contact number (s)** | |  | | | | | | | |
| **Email address** | |  | | | | | | | |

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| **Section 3 Declaration (please tick as appropriate)** | | |
| **See page 4 for types of documentation** | | **Please tick** |
| **A** | I am the patient and I **attach two proofs of my identity** |  |
| **B** | I have been asked to apply by the patient and **attach the patient written informed consent** |  |
| **C** | The patient lacks capacity to understand the request and **I attach evidence that I am acting for the patient e.g. Lasting Power of Attorney for Health, independent Mental Capacity Advocate (MCA)** |  |
| **D** | The patient is under the age of 16, I am the parent or acting in place of the parent and **I attached the patient written authorisation** |  |
| **E** | The patient is under the age of 16 years and lacked the capacity to understand the requirements. **I attach evidence that I am the parent or acting in place of the parent.** |  |
| **For request relating to deceased patients’ records** | | |
| **F** | Please state the reason for the application |  |
| **G** | I am the deceased patient’s personal representative and **I attach confirmation of my appointment** |  |

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| **I declare that the information given by me is correct to the best of my knowledge, I am entitled to apply for access to the requested records under the UK GDPR Article 15 for living persons, or under the Access to Health Records Act 1990 for deceased individuals:** | | |
| **Signature** |  | **Date** |
| **Print name** |  | |
| The Trust is not obliged to comply with a request until we received sufficient information to identity the patient and the applicant (if different) and to locate the information held.  Please see page 4 of this form for acceptable “Proof of Identity Documents”.  Please send copies **not** original documents.  **We may need to come back for additional information if you have not provided enough evidence**. | | |

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| **Patient authorisation to grant access to nominated representative** | | |
| **Signature** |  | **Date** |
| **Print name** |  | |

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| **Section 4 Details of Information requested** | | | |
| **To help us identity what information to provide from the health records you require please complete the table below and provide as much details as possible** | | | |
| **Period covered (From- To)** | **Hospital attended** | **Ward/Department/Speciality** | **Consultant (if known)** |
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| **Are x-rays images required?** | | **Yes** | **No** |
| **If yes then please email** [**imagetransferrequests@uhs.nhs.uk**](mailto:imagetransferrequests@uhs.nhs.uk) | | | |
| **Or write to the x-ray team at:**  Mail Point 136  C Level  SAB  University Hospital Southampton NHS Foundation Trust  Tremona Road  Southampton  SO16 6YD  Tel 023 8120 8613 | | | |

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| **Section 5 Please return the completed form and proof of identity to** |
| Disclosures Team  Mail Point 61  University Hospital Southampton NHS Foundation Trust  Tremona Road  Southampton  SO16 6YD |
| If you have any queries, please email [disclosures@uhs.nhs.uk](mailto:disclsoures@uhs.nhs.uk) or call 023 8120 4885  Please clearly state the name of the person whose record you are requesting, this will help us to deal with your enquiry promptly. |

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| **Verification Internal use only** | |
| Proof of identity received (List) |  |
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| SAR reference number |  |
| Initialled |  |
| Date |  |

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| **Proof of Identity Document (copies only please do not send originals)** | |
| **Applicant** | **Minimum Proof required** |
| **Patient** | * Copy of passport, driving licence or birth certificate * A photocopy of a utility bill dated within the last 3 months |
| **Representative of patient (e.g. relative, carer** | One of the following:   * Informed consent of patient * Copy of Lasting Power of Attorney * Evidence of appointment as Independent Mental Capacity Advocate (IMCA)  **and** the following * Two proofs of identity from patient’s representative |
| **Mother of a child patient** | One of the following:   * Mother’s name on child’s birth certificate * Mother’s name on child’s adoption certificate **and** the following: * Two proofs of identity from the mother |
| **Married biological father of child patient** | * Marriage certificate * Father’s name on the child’s birth certificate **and** the following: * Two proofs of identity from the father |
| **Unmarried biological father of child born before 01/12/2003** | * Father’s name on the child’s birth certificate * Court order granting the father parental responsibility * Copy of a parental responsibility agreement signed by both parents **and** the following: * Two proofs of identity from the father |
| **Unmarried biological father of child born on or after 01/12/2003** | One of the following:   * Father’s name on child’s birth certificate * Court order granting the father parental responsibility * Copy of a parental responsibility agreement signed by both parents **and** the following: * Two proofs of identity from the father |
| **Personal Representative of deceased patient i.e. executor or administrator of estate** | * Copy of the deceased’s will * Copy of Probate and the following: * Two proofs of identity of the personal representative |
| **Person who may have a claim arising from the patient’s death** | * Evidence supporting claim * Two proofs of identity of the applicant |
| **Person requesting copies of deceased patient’s records who does not fall into either of the above two categories** | * Two proofs of identity of the applicant * Relationship with the deceased patient * Reason for the request * Where possible, the specific parts of the health record required |