Healogics
Wound Healing & Lymphoedema Centres

SUBJECT ACCESS REQUEST: HEALTH RECORDS

Patient's Full Name	
Date of Birth	
Current Address & Postcode	
Contact Telephone Number	
Hospital Unit Number (if known)	
NHS Number (if known)	
Previous Address, if different at time of treatment	
Do you only wish to view your records?	YES/NO
Do you require a copy of your Health Records for a specific period of time and/or date?	YES, please specify the date(s): or NO
Do you require a copy of all of your Health Records?	YES/NO

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 Records referred to under the terms of The Data Protection Act 2018 (subject access requests/the right of access). **Tick as appropriate:**

☐ I am the patient

☐ I am a Police Officer / Law enforcement

☐ I have been duly authorised to act by the patient and attach the patient's written authorisation* (*confirm with patient the scope of health records requested)

☐ I have parental responsibility for the patient who is under the age of 18 and has consented to my making this request** (**confirm with the child the scope of health records requested; for complex requests relating to a child refer to DPO and/or https://ico.org.uk)

☐ I have parental responsibility for the patient who is incapable of understanding the nature of this request (authorisation attached) which is required on the grounds that:

Identification

In order to maintain confidentiality and to confirm your identity, before copies of the Health Records are released, please provide a copy of

Tick as appropriate

☐ Driving Licence
☐ or passport
☐ or birth certificate, Certificate of Registry of Birth or Adoption Certificate
☐ plus, a recent utility bill showing name and address (less than 3 months old)

I wish Health Record to be provided in the following format: Tick as appropriate

☐ Updates as agreed, to third party, via encrypted email

☐ Paper copy to be sent to my home address by recorded delivery

☐ Paper copy to my representative at the following address:

☐ *Paper copy for my collection from Healogics Wound Healing & Lymphoedema Centres

☐ *Paper copy for my viewing at a Healogics Wound Healing & Lymphoedema Centres

* To protect your information, if collecting or wishing to view please bring a form of photo identification with you.

☐ Scanned document sent to my private unsecure email address (please be aware that the use of a private unsecure email places your information at risk of being seen by other people)

☐ Encrypted scanned document sent to my private secure email address:

☐ Encrypted scanned document sent to my representative at their secure email address:

☐ Other, please state preference:

Identity Verified: YES/NO Healogics Administrator Signed: ……

Requestor Name (capitals): ……

Requestor Signature: …… Date: ……