Derbyshire Healthcare NHS
NHS Foundation Trust

Strictly confidential once completed

Application form to request access to your own health record

This form may be used if you wish to print it off, **complete by hand** and then send to us in the post. If you prefer to complete on line please either click on the link below or return to our Home page and select:
You are the patient and wish to access your own Health record by completing the application form on line

Please write clearly and enter as much information as you can because this will help us to deal with your request as quickly as possible.

If you have any queries or need help with completing your application form please do not hesitate to contact us either by telephone or by email:
Direct dial: 01332 623760 Switchboard: 01332 623700 ext 33760
dhcft.accesstoahealthrecord@nhs.net

Your personal details

Surname	
First name(s)	
Any previous name(s)	
Date of birth	_ _ / _ _ / _ _ _ _
NHS number if known	_ _ _ _ _ _ _ _ _ _
Gender	male / female [delete or circle]
Current address including postcode	
Any previous address during the time you have been under our care	
Telephone number(s), but only if it is suitable for us to contact you in this way	

If you have an answerphone, are you happy for us to leave messages if necessary?	

Confidentiality

We always do our utmost to maintain the confidentiality of our patients' records. Unless you are currently an in-patient on one of our wards, we will require you to send us **proof of identity** by attaching or enclosing a copy of one of the following: Medical Card - Drivers Licence - Birth Certificate - Passport - a letter from DWP/Jobcentre; plus a copy of a utility bill showing your current home address.

I have enclosed/attached (please list documents)	
If you are sending us paper copies in the post please indicate 'yes' if you would like them returned to you	

Details of records requested

Please provide as much information as possible, but we realise it may be difficult to remember everything accurately. It would be helpful if you could tell us the type of record you are wanting to access; some examples are:
medical/consultant's file, in-patient nursing, day service, occupational therapy, physiotherapy, community team, child and adolescent, learning disabilities.

Date(s) if known	Where seen, e.g. Ward, Outpatient Clinic, Day Centre, Community Team	Name(s) of your Consultant(s) or Health Professional(s)	Type(s) of record required

Our fees as set by the Data Protection Act 2018

Under the Data Protection Act 2018 the Trust will respond to all applications within a month. This service will be provided free of charge unless the request is deemed excessive or repetitive, in which case an administration fee may be charged.

How would you like to receive any information we are able to release to you?
Please answer yes or no

Would you like to receive a secure electronic copy of the copy information such as scanned images by email?	
Or Would you like to receive the information as paper copies?	
Paper copies would be posted to you using Royal Mail's Special Delivery which requires a signature on delivery. Would you like us to contact you to arrange a specific day for delivery when we have completed your request.	
Do you wish to view your record with a health professional on Trust premises?	

Data Collection Form

The Race Relations Amendment Act 2000, the Disability Discrimination Act 1995, the Disability Discrimination Act 2005 and the Gender Equality Duty (GED) of April 2007, requires us to make sure all our policies, practices, services and functions are fair and none of them create barriers for particular racial groups or disabled people. We would therefore be grateful if you would complete the following by placing an 'X' in the appropriate box:

I describe my ethnic category as:

Asian or Asian British

Indian	
Pakistani	
Bangladeshi	
Any other Asian background	

Black or Black British

Caribbean	
African	
Any other black background	

Mixed

White and Black Caribbean	
White and Black African	
White and Asian	
Any other mixed background	

White

British	
Irish	
Any other white background	

Other ethnic groups

Chinese	
Any other ethnic group	
Do not wish to disclose	

Declaration

I declare that the information I have given on this form is correct to the best of my knowledge

Please print your full name	
Signature	
Date	_ _ / _ _ / 20 _ _

Once completed please post all 4 pages to the address below enclosing any relevant documents:

Access to a Health Record
Records Management
Kingsway House East
Kingsway Hospital
Derby
DE22 3LZ