# Strictly confidential once completed



**Application form to request access to a deceased patient’s health record**

The Trust appreciates this is likely to be a distressing time for you and we wish to make the application process to see the health record as stress free as possible. With this in mind, please read this document fully and complete the relevant sections to assist us in completing your request as timely as we are able.

This form may be used if you wish to:

* **send us your request using email** or
* **type in the information and then print off to post to us**

**Rights of Access**

Requests for access to health records of patients who are deceased are dealt with through the Access to Health Records Act 1990 (AHRA). There are certain individuals who have rights of access to the health records of a deceased person:

1. **The patient’s personal representative**;

A personal representative is the executor or administrator of the deceased person’s estate. An example of where we are able to confirm that the applicant is a personal representative of the patient is when the applicant is, or has been, the Executor of the Will and they have sent us copies of documents as evidence of this relationship.

1. **Any person who may have a claim arising out of the patient’s death**;

If the application is in respect of a claim arising from their death, access cannot be given to information which is obviously not relevant to the claim.

The law requires us to ask you for information to determine your right to access the health record. If you are applying to see a deceased relative’s record we will need to see **one** of the following:

* Grant of Probate; or
* Letter of Administration; or
* Last Will and Testament

If you do not have any of these, we need proof of your entitlement to access the record, such as the deceased’s;

* Birth Certificate
* Marriage Certificate
* Death Certificate

**Limitations to accessing the record or part of the record:**

The Trust follows a health records retention schedule whereby records are no longer held for patients who passed away more than eight years ago.

We are required to check that any disclosure is subject to the recorded wishes of the deceased person.

We would consult with our health professionals to ensure there is nothing in the record which could harm a third person (such as information about the health of another person) if the record is to be released.

If the health record, or part of the health record is being withheld, we will advise you why, but we would not be able to give you specific details.

**Please include copies of the relevant documents** but if you have any queries, please do not hesitate to contact us – please see details at the end of this form.

|  |  |
| --- | --- |
| **I have enclosed:** (please list the document(s) i.e. Grant of Probate; orLetter of Administration;Last Will and Testament, or Birth/Marriage/Death Certificate) |  |
| If you are sending us paper copies in the post please indicate ‘yes’ if you would like them returned to you |  |

**Confidentiality**

We require you to send us **proof of identity** by attaching or enclosing a copy of a utility bill showing your current home address **and** a copy of **one** of the following photographic IDs: a Medical Card or Drivers Licence or Birth Certificate, or Passport.

|  |  |
| --- | --- |
| **I have enclosed** (please list documents) |  |
| If you are sending us paper copies in the post please indicate ‘yes’ if you would like them returned to you |  |

Please note that under the Access to Health Records Act 1990, there is no obligation for us to provide records created prior to 1991 unless our relevant Health Professional feels this will help in understanding any records created after this date. **If the records which you are requesting relate to a period prior to 1991**, we will have to give consideration to the reasons why you are making this request - please therefore clearly specify why you require these records.

Please now enter as much information as you can below. This will help us to deal with your request as quickly as possible. The boxes will expand as you type into them.

**Your personal details**

|  |  |
| --- | --- |
| Surname |  |
| First name(s) |  |
| Your relationship to the deceased |  |
| Current address including postcode |  |
| 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? (Y/N) |  |

**The patient’s details**

|  |  |
| --- | --- |
| Surname |  |
| First name(s) |  |
| Any other name known under |  |
| Date of birth |  |
| Date of death |  |
| NHS number if known |  |
| Gender (male or female) |  |
| Their address at time of death |  |
| Any previous address during the time they were under our care |  |

**Details of records requested**

Please provide as much information as possible, but we realise it may be difficult to do so. 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. Please continue on a separate sheet if necessary.

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

**Our fees as set by the Data Protection Act 1998:**

Copies will be charged at a maximum of £50

Viewing only will be charged at a maximum of £10

|  |  |
| --- | --- |
| I would like to be informed of the exact amount of the fee before the information is released to me. Please indicate ‘yes’ or ‘No’ |  |

**There will be no charge if** the patient was under our care within the past 12 months

|  |  |
| --- | --- |
| The patient was under our care in the past 12 months – please indicate ‘yes’ or ‘no’ |  |

**How would you like to receive any information we are able to release to you?**

|  |  |  |
| --- | --- | --- |
| Would you like to receive the information electronically as scanned images by e-mail **or** on an encrypted USB memory stick? Please indicate your preference (Y/N) | E-mail | USB Stick |
|  |  |
| **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. Please indicate ‘yes’ if you would like us to contact you to arrange a specific day for delivery when we have completed your request. |  |
| Do you wish to view the record with a health professional on Trust premises?  |  |

**Declaration**

To be completed by all applicants.

**Please note that any attempt to mislead Derbyshire Healthcare NHS Foundation Trust in order to obtain patient records may result in prosecution.**

|  |
| --- |
| I declare that the information I have given on this form is correct to the best of my knowledge and I am entitled to apply for access to the health records referred to above under the terms of the Access to Health Records 1990. [ ]  I am the deceased patient’s personal representative and attach confirmation ofmy appointment**or** [ ]  I have a claim arising from the patient’s death and request access to the health record on these grounds (please explain)……………………………………………………………………………………………………...……………………………………………………………………………………………………..……………………………………………………………………………………………………..……………………………………………………………………………………………………..Signed……………………………………………………………Date…………………………. |

**If you have any queries or need help with completing your application** please do not hesitate to contact us either by telephone or by email:

**Direct dial: 01332 623760 Switchboard: 01332 623700 ext. 33760**

Once completed you can either email your form attaching any relevant documents or post to us.

e-mail: dhcft.accesstoahealthrecord@nhs.net

Postal address:

**Access to a Health Record**

**IM&T and Records**

**Kingsway House East**

**Kingsway site**

**Derby**

**DE22 3LZ**

**Data Collection Form**

The Race Relations Amendment Act 2000, the Disability Discrimination Act 1995, the Disability Discrimination Act 2005, the Gender Equality Duty (GED) of April 2007, and the Equality Act 2010 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 background**

|  |  |
| --- | --- |
| Any other ethnic background (please specify) |  |

|  |  |
| --- | --- |
| Prefer not to disclose |  |

The Disability Discrimination Act 1995 defines disability as a physical or mental impairment which has a substantial and long term adverse effect on a person’s ability to carry out normal day to day activities.
Do you consider yourself to have a disability?

**Yes** [ ]  **No** [ ]

If “yes” what is the nature of your disability?

|  |
| --- |
|  |