

**Confidential**

**APPLICATION FOR ACCESS TO HEALTH RECORDS**

**DATA PROTECTION ACT**

Please note that there will be a minimum charge of £10 applicable for copies of the record to a maximum charge of £50. Cheques or postal orders should not be sent with the application form as an invoice will be sent following the provision of copies of the record.

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**PATIENT'S DETAILS**

Surname.....Forename.....

Date of birth.....Hospital No.....

Address.....

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Postcode.....Telephone No.....

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Please give dates of treatment or clinic attendances for which access to information is requested

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**DETAILS OF APPLICANT (if different from above)**

Applicants Name.....

Address.....

.....

Postcode.....Telephone No.....

**DECLARATION**

I declare that the information given in this form is correct to the best of my knowledge and that I am entitled to apply for access to the manual held health records referred to overleaf under the terms of the Data Protection Act 1998.

please tick as appropriate:

- \* I am the patient
- \* I am acting on behalf of the person named overleaf
- \* I am acting in loco parentis and the patient is under 16 years of age and is incapable of understanding the request or has consented to my making this request.

Signature of Applicant.....Date.....

**AUTHORISATION**

**Please complete this section if you are giving your consent to another person who is acting on your behalf.**

**Part 1:** I hereby authorise St George's Healthcare NHS Trust to release personal information that they may hold on me in respect of the information requested overleaf to

(Name).....to whom I have given consent to act on my behalf.

Signature.....Date.....

**Part 2:** In the case of a person under the age of 16 a responsible adult should certify where appropriate that the child understands the nature of the application

I (name)  
.....

Address.....  
.....

certify that the applicant understands the nature of this application.

Signature.....Date.....

**COUNTER SIGNATURE**

To be completed by an independent person to confirm your identity.

I (name).....certify that the applicant has been known to me as (state capacity).....for .....years and that I have witnessed the signing of the above declaration.

Signed.....Date.....

Name..... Profession.....

Address.....

.....Telephone.....

Please return the completed application to the address below:

The Health Records Manager  
Medical Records Department  
St George's Healthcare NHS Trust  
St George's Hospital  
Blackshaw Road  
London, SW17 0QT

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**OFFICIAL USE ONLY**

Health Professional Advising .....

Access provided on .....copies required.....

Signature.....Designation.....

**FURTHER ACTION**

Corrections requested.....

Copies provided.....

Fee applicable.....Invoice raised.....

Signature.....Date.....