**Application for access to Medical Records held by**

**Southport and Ormskirk Hospital NHS Trust**

PLEASE COMPLETE THIS FORM CLEARLY & IN BLOCK CAPITALS

A copy of a form of photo identification is required for all access requests (e.g. passport, driving license NUS card).

For all requests a copy of a utility bill or bank statement no more than 3 months old will also be required to confirm address**, please provide your Identity documents with this form**. (These will be destroyed once the request is closed)

The Trust has **one month** to respond to this application, from date of receipt.

|  |  |
| --- | --- |
| **Patient Details** (record to be accessed) | |
| Patient Name | Mr / Mrs / Miss / Other |
| Previous Surname (If applicable) |  |
| Date of Birth |  |
| Address  Post Code |  |
| Contact Telephone Number |  |
| Email Address |  |
| Hospital Number (If Known) |  |

|  |  |
| --- | --- |
| **Details of Records Required (Please be as specific as possible)** | |
| If you require Radiology (X-Ray) please tick:  Radiology reports  Radiology images on disk | Dates of Interest: |

|  |  |
| --- | --- |
| **Details of person making the application** | |
| Full Name | Mr / Mrs / Miss / Other |
| Address  Post Code |  |
| Contact Number |  |
| Email Address |  |

|  |  |
| --- | --- |
| **Declaration (**Please select from the below) | |
| I am the patient |  |
| I have legal parental responsibility/ next of kin for the patient, who is under 13 or has consented to me making this application |  |
| I am acting on behalf of the patient with their written and signed consent |  |
| I am acting on behalf of the patient, I have power of attorney (Health & Welfare) |  |
| I am applying on behalf of the deceased patient |  |
| I am applying on behalf of the deceased patient, have a claim arising from their death and wish to access the information relevant to my claim on the grounds of (Please detail):  ................................................................................................................................  ................................................................................................................................ |  |

Please note that it is an offence under section 55 of the Data Protection Act 2018 to unlawfully obtain information.

I declare that the information provided on this form is correct to the best of my knowledge. I confirm that I am entitled to make this application.

**Name of Applicant:**..............................................................................................

**Signature:**....................................................................................**Date:**................

**Name of Patient (If applicable):**..........................................................................

**Signature:**....................................................................................**Date:**................

**Please send the completed form and documentation to: Access to Health Records, Southport and Ormskirk Hospital, Town Lane, Kew, Southport, PR8 6PN. If you require assistance please call 01704 704616 or email**

[soh-tr.access-to-health@merseywestlancs.nhs.uk](mailto:soh-tr.access-to-health@merseywestlancs.nhs.uk)