

Subject Access Request – Data Protection Act 2018

| 1. Identity of patient about whom in | formation is r | requested (please print clearly & use dark ink) | |
|--|---|---|---------------|
| Title: Dr / Mrs / Miss / Ms / Mr / Master / Other | Full name: | | |
| | Previous name/s | s (if applicable): | |
| Current address: | | Previous address (with date of change): | |
| | | | |
| Date of birth: | | NHS number (if known): | |
| | | Hospital number (if known): | |
| Contact phone number (including area code): | | I give my permission for messages to be left on the corphone number I have provided: ☐ YES ☐ NO | ntact |
| I am the patient (aged 16+): ☐ YES – G | o to section 3 | □ NO – Go to section 2 | |
| 2. If you are NOT the patient please details: | tick below as | appropriate and add your contact | |
| I am acting for the patient and I attach the pati | ent's written autho | prisation/consent (signed letter) | |
| | | I I attach evidence that I am acting for the patient I Capacity Advocate (IMCA) or Court Order) | |
| they are not capable of understanding the req | uest. I attach prod | ears old or the patient is aged 13-16 years old and of of my parental responsibility (the child's full birth ate, a copy of the marriage certificate or a Court | |
| | sibility (the child' | ars old and they have consented to my making of this s full birth certificate or if the father is not named r a Court Order) * NB: the child must sign | |
| | | sidered to have the capacity to give or refuse conser less there is a reason to suggest otherwise. | nt to |
| I am the deceased patient's Personal Represe confirmation of my appointment (copy of a W | | | |
| I have a claim arising from the patient's death an explanation or evidence of the nature o | | ss information relevant to my claim. Please provide nsidered. | |
| Records Act 1990, if you are not an admindenth, your request will need to be considered by the considered to be considered by the consider | istrator/executor ered by the Trus ease put your red Enquiries, Inforr | quest in writing, detailing your reason for requesting nation Governance, Box 153, Addenbrooke's Hospit | nt's ; the |
| Hills Road, Cambridge, CB2 0QQ, alternati | vely email: cuh.g | dpr@nhs.net | |

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| Details of the Applicant (if not the patient): |
|---|
| Relationship to patient: |
| Name and address of Applicant: |
| Contact number and e-mail address: |
| 3. Dates and types of records requested: |
| You do not have to give a reason for applying for access to your health records. However, to help the NHS save time and resources, it would be helpful if you could detail below, the periods and/or parts of your health records you require, i.e. consultant name, department name, diagnosis, etc. It will help us to locate the records if you can give us as much information as possible: Please use the space below to document and continue on page 4 if necessary. |
| page : :::::::::::::::::::::::::::::::::: |
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| PARIOLOGY |
| RADIOLOGY |
| Please tick the box if you would like to receive x-rays/scans relating to your request \square |
| PLEASE NOTE: Radiology cannot be released before you have received the result(s) of your imaging. If yo still wish to receive a copy of your imaging once your results have been disclosed, please re-apply. |

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We will aim to process all valid applications within **one calendar month** of receipt of all the information required to process the request. The information will be provided free of charge. Please do not contact our office before one calendar month to chase for copy medical records. If in the unlikely event, your request will take longer than one calendar month we will be in touch with an estimated timeframe for receipt.

If a request is considered to be manifestly unfounded or excessive, particularly if it is repetitive then the request may be refused or a reasonable fee will be charged to cover the administrative cost of providing the information. If the request is refused an explanation will be given and you will have the right to appeal to the Information Commissioner's Office (ICO).

| Where you would like the copie | s of information to be sent: |
|---|---|
| Health records and Radiology will be pro MFT@ams-mft.com | vided by email using a secure file transfer platform. You will receive an email from |
| Please provide the email address (one e | mail address ONLY) you wish the health records and/or Radiology to be sent to: |
| Enter email here: | |
| security reasons they will no longer b | records and/or radiology images within 30 days of receiving the email as for e accessible after this time. edical record files or radiology images to tablets, iPads and mobile devices. |
| _ | gy images can only be downloaded to a computer. The download speed will dth/speed. If you do not have access to a computer, please contact us to jpt. contact details below. |
| 4. Declaration and Authorisation | • * |
| Signature of Applicant: | Print Name: |
| | |
| Signature of child aged 13-16: | Print Name: |
| | |
| Date: | |
| | |

Note: A typed name is not acceptable, a signature is required. We will accept a scanned digital signature. If this is not possible, please physically sign and either scan and email the form or post it to us.

Return form to:

CB2 0QQ

Access to Health Records Box 82 Addenbrooke's Hospital Hills Road Cambridge

Departmental telephone numbers:

01223 216755 (Mon-Thurs 08:00-16:30 & Fri 08:00-13:30) 01223 216327 (Mon-Fri 08:30-16:30) 01223 216298 (Mon, Wed & Fri 07:00-15:00)

Or e-mail a scanned copy to: add-tr.cuhaccesstohealthrecords@nhs.net

Proof of identity – Please do not send any original documents. You can send printed copies or electronic copies.

(A) If you are applying for your own health records you will need to supply copies of the following documentation:

- 1. 1 x copy of current photo ID (e.g. a passport or driving licence)
- If you do not hold photo ID your full birth certificate/marriage certificate/adoption certificate or name change certificate and 1 x copy of a document showing your current address (e.g. utility Addenbrooke's Hospital | The Rosie Hospital

National Institute for Health and Care Research - Cambridge Biomedical Research Centre and a member of Cambridge University Health Partners



bill, bank statement, credit card statement, benefit book or pension book) – this must be dated within the last six months.

OR

(B) If you are applying on behalf of someone else you will need to supply copies of all documentation listed in (A) above as well as a copy of the relevant document from the statement you have ticked in Box 2.

IMPORTANT: When returning your application form please ensure you provide copies of the documents requested above – we are unable to process any requests without this information. Incomplete applications will be returned with correspondence stating what would be required for the application to be accepted.

Any information you have supplied in making this request will be treated in confidence. It will only be used for the purpose of carrying out your request in accordance with the Data Protection Act 2018 or Access to Health Records Act 1990. After your request is completed a printed version of your application form will be retained for a period of six months, after which date it will be securely destroyed.

| | Application checklist: |
|-------|--|
| | Is your contact information correct? □ Have you completed all the relevant sections? □ |
| | Have you attached acceptable identification? □ Have you signed the form? □ |
| Dates | and types of records requested continued: |
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