

St Oswald's

**APPLICATION FOR ACCESS TO PERSONAL DATA  
(INCLUDING HEALTH RECORDS)**

**DETAILS OF THE RECORD TO BE ACCESSED (by the Data Subject's Representative)**

**Data Subject's Details**

Surname:			
Forename(s):			
Address:			
Postcode:		Telephone Number	

Hospice Record Number and/or NHS Number (if applicable)	
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Date of Birth	
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**Details of Application:**

Please provide details of the record(s) held that you wish to access, e.g. Health Record, Personnel Record etc. Please provide any information which will help us to identify the record/relevant part of the record, e.g. name of doctor or clinician, illnesses, time period, title of post held, specific dates, etc. You may also provide details of the reason you require access to the information if you so wish. Please note that you may be requested to provide proof of identification i.e. driving licence with photograph or passport.

**Details of Applicant:**

Surname:			
Forename(s):			
Address:			
Postcode:		Telephone No:	

Please tick appropriate box below:

- I have been asked by the Data Subject and attach the Data Subject's written authority.
- I am acting in loco parentis and the Data Subject is under age 16 and is incapable of understanding the request/has consented to my making this request.
- I am authorised by a Court of Law.
- I am the personal representative of a deceased patient and I am applying for access to the patient's health record.

Declaration (to be completed by Applicant)

**I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the personal data referred to on this application form under the terms of the Data Protection Act 1998/Access to Health Records Act 1990 and that any information accessed by me regarding this application will be treated in the strictest of confidence.**

Applicant's Signature ..... Date:  
.....

Certification (Witness to Applicant's Signature)

**I certify that I am**

(Name) .....  
.....

**and that I have known the applicant for ..... years as an employee/client/patient/personal friend/other (please state). I have witnessed the applicant sign this form.**

Witness' Signature ..... Date: .....