**Application for access to medical records**

**Details of the record to be assessed:**

|  |  |
| --- | --- |
| **Patient Surname** |  |
| **Forename(S)** |  |
| **Date of Birth** |  |

**Details of the person who wishes to access the records, if different to above:**

|  |  |
| --- | --- |
| **Surname** |  |
| **Forename(S)** |  |
| **Address** |  |
| **Telephone number** |  |
| **Relationship to patient** |  |

**Tick whichever of the following statements apply:**

* I am the patient.
* I have been asked to act by the patient and attach the patients written authorisation.
* I am acting in Loco Parentis and the patient is under age 16, and is incapable of understanding the request / has consented to me making this request.

\*Delete as appropriate

**PLEASE TURN OVER**

* I am the deceased patients personal representative and attach confirmation of my appointment.
* I have a claim arising from the patients death and wish to access information relevant to my claim on the grounds that … (please supply your reasons below).

**Your signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notes:**

Please use the space below to inform us of certain periods and parts of your health record you may require, or provide more information as requested above. This may include specific dates, consultant names, locations and parts of the records you require e.g. written diagnosis and reports.