**REQUEST FOR RECORDS (SUBJECT ACCESS REQUEST) FORM**

 In order to comply with your request, please inform us with precisely what information is required.

 Once this information, alongside a copy of your photo ID is received, we will provide the information within one month. Where we are unable to meet this deadline, we will write to you to explain why.

Generally, there is no charge for the information. However, organisations can charge a “reasonable fee” for the administrative costs of complying with a request when it is manifestly unfounded or excessive, particularly if it is repetitive. If this applies to your request, a member of staff will contact you to explain the fee and the reasons it is being charged.

**Please tick a box below to let us know what information you require:**

**\*\*Please note, it may be quicker for us to provide particular parts of a record compared to a whole record.**

**[ ]** Whole record – this includes consultation notes, clinical correspondence, investigation results, copies of any scansetc **OR**

**[ ]** Partial records. Please provide date range: From       To

 **OR pick one or more from the list below:**

**[ ]** Scanned images ONLY e.g. a disc showing the 'pictures' produced

 by MRI or CT scans, X-Rays

**[ ]** Written X-Ray and Scan reports (this does not include the images, just the results)

[ ]  Letters [ ]  All **or** provide date range: From       To

[ ] Nursing Notes [ ]  All **or** provide date range: From       To

[ ]  Rehabilitation Team Notes e.g. physiotherapy, speech and

language therapy [ ]  All **or** provide date range: From       To

[ ]  Other information. Please provide details and a date range

**Who is making this request?**

**If you are an employee, skip to Section D**

**[ ]** I am the patient (Please fill out Section A below)

[ ]  I am acting on behalf of the patient (Please skip to Section B)

**Section A – ‘I am the patient’**

Please provide us with the following details:

Name (First Name, Surname):

Date of Birth:

NHS number (if known):

Hospital number (if known):

Current address:

Contact telephone number and/or email:

**We will need you to send a copy of photo ID with your request to prove your identity**

**Section B – ‘I am acting on behalf of the patient’**

**Is the patient deceased?**

**[ ]  Yes –** skip to **Section C**

**[ ]  No –** continue below

**Who are you?**

[ ]  A parent where the patient is under 16, and has consented to me making this request

[ ]  A family member of the patient

[ ]  A legal representative of the patient

Your name:

Your relationship with the patient:

Your contact details:

**This section continues onto the next page**

**Section B – ‘I am acting on behalf of the patient’**

Patient Name (First Name, Surname):

Patient Date of Birth:

NHS number (if known):

Hospital number (if known):

**We will need a copy of photo ID from you, and proof that the patient has**

**consented to you receiving their information**

**Section C – ‘I am acting on behalf of the patient’**

You will only need to complete this section if the patient is deceased.

**Who are you?**

**[ ]** The executor/executrix of the patient’s will, or have been granted probate in

 the absence of a will. **Please provide either copy of the will/letter of**

 **administration/grant of probate**

**[ ]** I am the deceased’s personal representative. **Please provide proof**

 **of appointment**

**[ ]** I have a claim arising from the patient’s death and wish to access information

 relevant to my claim (please provide evidence of this claim)

[ ]  Other. Provide details:

**Please provide details of the deceased:**

Patient Name (First Name, Surname):

Patient Date of Birth:

NHS number (if known):

Hospital number (if known):

 **Section D - I am an employee/ex-employee at the Trust:**

Name:

 Date of Birth:

 NI number:

 Contact details:

 **You will need to provide a copy of your photo ID to prove your identity.**

Please provide a description of the information you require, and date ranges if appropriate:

Please provide information about any persons who you believe may hold copies of the information

 requested. This is particularly useful if the data requested includes letters and e- mails as these

may be held in local e-mail accounts and not network drives therefore not identified by routine

system data searches. Please continue on a separate sheet if necessary.

 **Patient consent**

 I hereby authorise the Clatterbridge Cancer Centre NHS Foundation Trust to release the information requester to myself, or to the person making the request on my behalf.

Signature

Date

 \*(A scanned or digital signature is acceptable)

## Please return the completed form to:

## ccf-tr.subjectaccessrequests@nhs.net

## OR

## Medical Records

Assistant Service Manager Administrative Services Department

Clatterbridge Cancer Centre NHS Foundation Trust

Clatterbridge Road

Bebington

Wirral

CH63 4JY

Tel: (0151) 556 5714

**Employment Records**

Workforce and OD Administrator

Workforce & OD Department

Clatterbridge Cancer Centre NHS Foundation Trust

Clatterbridge Road

Bebington

Wirral

CH63 4JY