

Birmingham Women's Health Care

NHS Trust

Request for Access to Personal Information
(Request for Subject Access under the Data Protection Act, 1998)

Please read the accompanying notes (Appendix A) before filling in this form.

PART A: IDENTITY OF PERSON ABOUT WHOM INFORMATION IS REQUESTED (See Note 1)

Surname	(Formerly)
Forenames	Date of birth
Current address	Previous address
Telephone number	GP
Approximate date of change of address	Hospital number
Relationship with Trust:- Patient/Staff/ Supplier/Job Applicant/Correspondent/Blood Donor/Working contact *	Current/Previous Staff * Payroll Number

* Delete as appropriate

PART B: DETAILS OF RECORDS TO BE ACCESSED /INFORMATION REQUIRED (See Note 2)

Hospital	Consultant / Department	Condition or illness/reason for visit/contact	Date	Medical Records	X-rays	Other - please specify

PART C: ACCESS (See Note 3)

(A) I wish to view the records personally at the hospital

(B) I wish to have a copy of the records sent to me

Please tick appropriate box

PART D: DECLARATION (See Note 4) To be signed in the presence of the person confirming identity

I declare that the information given in this form is correct to the best of my knowledge and that (tick one box only)

I am the patient/access subject named in part A (complete parts D and E only)

I have been authorised to act by the patient/access subject (complete parts D,E and G)

I am the applicant's representative. The applicant is incapable of understanding the request (by virtue of age, is severely mentally ill, is severely mentally handicapped). (Complete parts D and E only)

PART D: DECLARATION (Continued)

Signed:	Date:
Address	
Telephone number	
Relationship to patient/access subject	

PART E: CERTIFICATION OF APPLICANT (See Note 5)

I Certify that I have
known.....

for years and certify that I have just witnessed this person sign this Request for Personal Information under the Data Protection Act, 1998. I further confirm that I am an independent witness and that the applicant is known to me under this name as an employee/client/patient/personal friend.*

* Delete as applicable

Signed	Date
Address	
Daytime telephone number for confirmation of identification	

WARNING

You are advised that the making of false or misleading statements in order to obtain access to personal information to which you are not entitled is a criminal offence.

PART F: PAYMENT (See Note 6)

The charges for this service are listed on our web site. Please enclose your cheque, made payable to *Birmingham Women's Hospital*, with this application.

PART G: AUTHORISATION WHERE APPLICANT IS NOT THE PATIENT / ACCESS SUBJECT (See Note 7)

I hereby authorise release of my health records/information, as specified in Part B, to the person named in Part D above. I declare that I am the patient/applicant named in Part A of this form.

Signed	Date
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Please return this completed form to: Medical Records, Birmingham Women's Hospital, Metchley Park Road, Edgbaston, Birmingham, B15 2TG.