NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Application Form – Access My Records

Please read the accompanying guidance: "Access to Health Records Information Leaflet" regarding the rights of access together with charges that may be associated with your application, to assist you in completing this application form.

DETAILS OF APPLICANT:			
Surname:		**Forename(s):**	
Address:			
Email address:			
Telephone number:		**May we leave an answer phone message?**	**Yes / No**

Please tick the appropriate boxes:

- ❑ I am the patient and over the age of 16 years.
- ❑ I am the person who has legal responsibility for the patient, who is under the age of 14.
- ❑ The patient is over 14 years of age and under 16 years of age, has consented to my making this request and has authorised my application.
- ❑ I am acting on behalf of the patient (aged over 16). Please be advised that you will need to provide proof that you have power of attorney or that you are the legal representative.
- ❑ I am the deceased patient's personal representative and attach either letters of administration or a grant of probate
- ❑ I have a claim arising from the patient's death and wish to access information relevant to my claim on the grounds that:

_____

_____

_____

_____

Name of Patient:

_____

Signature:

_____

–

Unless you have requested paper copies, records will be sent out to you via an delivery system. The password to open this document will be emailed to you.

DETAILS OF THE PATIENT:				
Surname:		**Forename(s) :**		
Address:				
Date of birth:		**Title:**		**Male/Female**
NHS number:			**Hospital number:**	

If the name and / or address were different from above during the time period(s) to which the application relates - please give details below:

PREVIOUS DETAILS:		
Previous Surname:	**1)**	**2)**
Previous Address:	**1)**	**2)**
Applicable Dates:		

To help the NHS save time and resources it would be helpful if you could provide details below, informing us of the parts of the health records you require, along with details which you may feel have relevance i.e. dates, consultant name, location, written diagnosis and reports etc.
Please use the space below to document, continuing on another page if necessary.

Which records are you requesting? (*Please tick the applicable boxes*)

- ❑ WWL Hospital Services (Royal Albert Edward Infirmary, Leigh, Wrightington, Thomas Linacre, Boston House)

- ❑ WWL Community Services (Walk In Centre, District Nurse, Mental Health etc.)

❑ Both

WWL Services:

WWL HOSPITAL / CLINIC CONTACTS (Please provide as much information as possible)					
Date Attended	**Hospital**	**Ward / Clinic**	**Consultant**	**Type of Record – please indicate**	**Hospital No.**
				❑ Case notes ❑ X-rays ❑ A&E Records ❑ Photographs	
				❑ Case notes ❑ X-rays ❑ A&E Records ❑ Photographs	
				❑ Case notes ❑ X-rays ❑ A&E Records ❑ Photographs	

WWL Community:

WWL COMMUNITY CONTACTS (please provide as much information as possible)			
Name of Service* *(Podiatry, Dietetics etc)*			
**if you are unsure of the service can you provide detail of the treatment received: mental health, diabetic care etc.*			
Where were you treated? *(Clinic, walk in, home etc.)*			
Health Professionals Name *(if known)*			
Month and Year of care or treatment *(if known)*		**Month and Year care or treatment ended** *(if known)*	

Do you wish to arrange an appointment to view the original records in the presence of a member of staff? Please note this will be a member of the Information Governance Team who is not medically trained.

YES / NO

I would prefer to receive the records as paper copies.

YES / NO

In order that we can process your application request efficiently would you please advise us if this application is in connection with an ongoing complaint against the Trust?

YES / NO

If yes, please enter your complaint reference number below:

_____

Declaration

I declare that the information supplied above is correct to the best of my knowledge and that I am entitled to apply for access to the above record(s) under the terms of the Data Protection Act 2018. I enclose two forms of identification one of which must be a photocopy of photographic identification; the other must be a utility bill.

We cannot process your application without proof of identity.

Signature: _____

Date: _____

Please return this form to:-

Access to Health Records Department
Knowsley House
RAEI
Wigan Lane
Wigan

Wrightington, Wigan and Leigh NHS Foundation Trust

WN1 2NN
Tel:- **01942 822541**

For Office Use Only	
Date form was received	
Name of staff who received information	
ID has been checked	
Additional Information requested	
Name of staff who reviewed information	
Date SAR response sent	
Method sent (CD, AMS, Post etc)	