|  |  |
| --- | --- |
| **ACCESS TO YOUR HEALTH RECORDS**  **KEEPING PATIENTS INFORMED** | A blue and white logo  Description automatically generated |

**Access to your records**

The UK Data Protection Act 2018 gives you the right to know whether we hold information about you and a right to request a copy of that information. This is known as a ‘Subject Access Request.’

**How do I apply to see my health records?**

You can ask the health professional responsible for your care if you can view/discuss records relevant to your current treatment. All other applications should be made in writing; an application form is attached to this leaflet.

**Who can apply to see my health records?**

You can make your own application to see your records, or you can authorise someone else to make the application and to look at them for you. A parent or guardian, a patient representative, or a person appointed by a Court can also apply. You can apply to see the record of person who has died if you have a claim arising from that person’s death. The holder of the record must be satisfied that the applicant has the authority.

**How much does it cost?**

This is free; however, a charge can be made when a request is unfounded or excessive, particularly if it is repetitive or if further additional copies have been requested.

**How long does it take?**

After you give NHS staff enough information to identify you and your records you will receive the information

within one calendar month. You can collect the information in person, in some cases you may choose for it to be sent by secure email or Royal Mail and in these circumstances Recorded Delivery will be used.

**What records can I see?**

You can apply for access to records that NHS Western Isles holds about your health. For GP Health information contact your Practice Manager at the relevant GP Practice. For treatment carried out in another Health Board, requests should be directed to the relevant organization.

**Reasons why you may not be able to see your records.**

Some information on your records may be kept from you. For example, you won’t be able to see information that could:

* Cause serious harm to your physical or mental health, or someone else’s.
* Identify another person (except NHS staff who have treated you) unless that person gives permission.

**How long are records kept?**

Health Records are kept for a limited time. Examples include:

* Adult Health Records – 6 years after the date of last contact.
* Maternity Records – 25 years after the birth of the last child
* Childrens and Young People’s Records – until the child or young person’s 25th birthday
* Mental Health Records – 20 years after the date of last contact

|  |  |
| --- | --- |
| **For any queries or where to Return the Application Form:** | **If you disagree with any decisions regarding access to your health records, please contact:** |
| Information Governance Manager  NHS Western Isles  Health Board Office  37 South Beach  Stornoway  Isle of Lewis  HS1 2BB  Email: [wi.infogov-wihb@nhs.scot](mailto:wi.infogov-wihb@nhs.scot) | Complaints Officer  NHS Western Isles  Health Board Office  37 South Beach  Stornoway  Isle of Lewis  HS1 2BB  Email: [wi.nhswicomplaints@nhs.scot](mailto:wi.nhswicomplaints@nhs.scot) |

|  |  |
| --- | --- |
| **APPLICATION FORM**  **ACCESS TO YOUR HEALTH RECORDS** | A blue and white logo  Description automatically generated |

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

**SECTION 1 - PATIENT DETAILS**

|  |  |
| --- | --- |
| Surname: | Forename: |
| Date of Birth: | |
| Address: | |
| Post Code | |
| Telephone Number: | Mobile Number: |
| Email Address: |  |

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

|  |  |  |
| --- | --- | --- |
| Previous Surname: | 1. | 2. |
| Previous Address: |  |  |
| Dates From/To |  |  |

**SECTION 2 - RECORD DETAILS**

Please provide as much information as possible in the table proved. Give full details of all the treatment periods you are interested in. Please add any additional comments in the ‘other’ box.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please tick all record types you would like to**  **receive copies of:** | **Western Isles**  **Hosp.** | **Uist and**  **Barra**  **Hosp.** | **St Brendan’s**  **Hosp.** | **Dates** |
| General Hospital Services (such as A&E, Inpatient and Outpatient Services) |  |  |  |  |
| Allied Health Professional Services (such as  Physiotherapy, Dietetics, Podiatry, Speech & Language)  **(Please Specify Below)** |  |  |  |  |
| Community Services (such as Community Nursing,  Health Visiting, Community Occupational Therapy)  **(Please Specify Below)** |  |  |  |  |
| Radiology Images and/or Results |  |  |  |  |
| Maternity/Obstetrics |  |  |  |  |
| Dental |  |  |  |  |
| Specialist Services (such as Community Psychiatric  Nursing, Macmillan Nursing, Audiology, Nurse Specialists including Diabetes, Neurology, Cardiac and Respiratory)  **(Please Specify Below)** |  |  |  |  |
| Other **(Please Specify Below)** |  |  |  |  |
| ***Please detail which specific services you require health records from.*** | | | | |

**SECTION 3 - DECLARATION**

*Please tick the appropriate box*

I am applying to see my own record (go to section 6).

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 health record referred to above under the terms of the Data Protection Act 2018

**Applicant Signature: \_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**Applicants Representative:**

If you are not the named person in the Patient Details Section above, please tick the appropriate box and sign below, and then complete section 4 and 5:

I am the agent for the patient named who has authorised me on his/her behalf.

I am the deceased patient’s representative and attach confirmation of my appointment by a court to

manage the patient’s affairs e.g., executor for the estate or have a claim arising from the patient’s death (evidence required).

I am the parent/guardian of the patient who is:

Under 16 (If a child understands the request, he/she can refuse access)

Incapable of understanding the request

I have been appointed by the Court to manage the affairs of the patient (evidence required).

**Applicant Signature: Date:**

**SECTION 4 - APPLICANTS DETAILS (only complete if you are applying to see a record on behalf of someone else):**

|  |  |
| --- | --- |
| Surname: | Forename: |
| Date of Birth | |
| Address | |
| Post Code | |
| Telephone Number: | Mobile Number: |
| Email Address: |  |

**SECTION 5 – PERMISSION**

You must fill in this section if you are the person named in section 1 and you have given the person named in section 3 permission to act on your behalf.

I give NHS Western Isles permission to provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (enter the name of the person acting on your behalf) the requested personal information about me. I have given them permission to act on my behalf.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECTION 6 – COUNTERSIGNATURE**

Due to the confidential nature of data held by Health Boards it is essential for us to obtain proof of your identity and your right to receive any relevant data. The person who countersigns your application is only required to confirm your identity and witness you signing the ‘Declaration’. There is no requirement for this person to either see the contents of the rest of the form or to give any assurance that the other particulars supplied are correct.

I (insert full name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certify that the applicant (insert name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has been known to me as a (insert in what capacity e.g., employee, client, patient etc.) \_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for years and that I have witnessed the

signing of the above declaration.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your counter signatory **should**:

• have known you for at least two years

• live in the UK

Your counter signatory **should not**:

• be related to you by birth or marriage

• be in a personal relationship with you

• live at the same address as you

**PROOF OF IDENTITY:**

If no countersignature is available, the table below outlines the proof of identity required:

|  |  |
| --- | --- |
| **Type of application** | **Type of identification requirements – please do not send original documents** |
| Individual applying for their own records | Two forms of identification required – one of which must be photographic – e.g., passport, driving licence, NEC or Young Scot card and one with your address details e.g., a utility bill, landline telephone bill, local authority council tax bill, bank statement – with all transactions ‘blacked out’, showing your name and address. |
| Application from a representative on behalf of an individual | Two forms of identification from the representative (as above) and one form of identification from the patient. |
| Application from a person with parental responsibility applying on behalf of their child | Child’s birth certificate, and two forms of identification (one to be photographic) from the person with parental responsibility. |
| Application from a representative of a deceased individual under the access to Health Records Act 1990 | Two forms of identification from the representative (as above) and proof of relationship to the deceased and/or executor status. |