Dear

Thank you for your enquiry regarding the disclosure of your medical records under the Data Protection Act 1998.

We take confidentiality of our patients very seriously so we need to be assured of your identity before releasing any information to you. The details of what we need to see are at the back of the form. We are entitled to make these checks under Section 7 (3) of the Data Protection Act 1998. Please note that we may notify the police in the event of a fraudulent application.

The Data Protection Act 1998 requires us to process your request within forty days from the time we receive the application, including your proof of identity.

Please note there is a charge for this service and you will be invoiced after the process is completed. Please see table below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>To view records in person</td>
<td>£10.00</td>
</tr>
<tr>
<td>Photocopying charge per sheet</td>
<td>25 pence</td>
</tr>
<tr>
<td>Computerised records only (letters, blood and imaging reports)</td>
<td>£10.00</td>
</tr>
<tr>
<td>Eastman Dental Hospital x-rays</td>
<td>£5.00 per small sheet of 4-5 peripical x-rays and £10.00 for large x-rays (OPGs and Lat Cephs)</td>
</tr>
<tr>
<td>Admin fee only if not seen by UCLH health professional within 40 days</td>
<td>£10.00</td>
</tr>
<tr>
<td>A&amp;E records only (depending on date/s)</td>
<td>Estimate between £5.00-£10.00 (varies)</td>
</tr>
<tr>
<td>Maximum fee for the service</td>
<td>£50.00</td>
</tr>
</tbody>
</table>

Yours sincerely,

Medical Records
REQUEST FOR ACCESS TO MEDICAL RECORDS
Under the Data Protection Act 1998

PATIENT DETAILS
First name: ___________________________ Surname: ___________________________
Date of birth: ___________________________ Previous surname (if applicable): ___________________________
Address: ___________________________
_________________________
_________________________
_________________________
Postcode: ___________________________
*Email address: ___________________________
Hospital number (if known): ___________________________

REQUESTER’S DETAILS
Please complete this section only if you are requesting notes on behalf of the patient, ie, you are the patient’s nominated representative or next of kin.
First name: ___________________________ Relationship to patient: ___________________________
Surname: ___________________________
Mobile telephone: ___________________________
Address: ___________________________
_________________________
_________________________
_________________________
Postcode: ___________________________
*Email address: ___________________________

If the patient is deceased, please state your legal entitlement under the Access to Health Records Act 1990:

__________________________________________

*Please note we cannot send medical records via email.

For official use only
Proof of identity ___________________________
Proof of address □ Signed __________ 1 Date ____________________________
RECORDS REQUIRED
Please tick the appropriate box(es)

☐ All hospital records

Or specific records
☐ Accident & Emergency Department records
☐ Maternity records
☐ Intensive care records (provided on disc)
☐ Therapy records
☐ X rays/images (provided by the Imaging Department on disc)
☐ Blood results
☐ Imaging reports
☐ RNTNE audiographs, photographs
☐ Other ____________________________________________

☐ To view medical records
(If you want to view your records please make an appointment with the ICT Records Release of Information Team on 020 3447 7806/9849)

WHICH HOSPITAL RECORDS WOULD YOU LIKE COPIES OF?
Please tick all appropriate box(es)
☐ University College Hospital
☐ Elizabeth Garrett Anderson Wing
☐ Heart Hospital
☐ Hospital for Tropical Diseases
☐ Macmillan Cancer Centre
☐ National Hospital for Neurology and Neurosurgery
☐ The Royal London Hospital for Integrated Medicine
☐ Royal National Throat, Nose and Ear Hospital
☐ Eastman Dental Hospital

DECLARATION
I declare that the information given on this form is correct to the best of my knowledge
(Please tick the relevant box)
☐ a) I am the patient
☐ b) I am acting on behalf of the patient
Signature: ____________________________  Signature: ____________________________

Date: ____________________________  Date: ____________________________
Patients or their representative are required to provide one form of photographic identity from list A and one proof of address from list B.

<table>
<thead>
<tr>
<th>A Photographic proof</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Driving licence (if you have a UK licence, this can be used as proof of address also)</td>
</tr>
<tr>
<td>2 Passport</td>
</tr>
<tr>
<td>3 UK firearms licence</td>
</tr>
<tr>
<td>4 HM Forces ID card</td>
</tr>
<tr>
<td>5 Certified photograph*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B Proof of address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Recent utility bill (no more than 3 months old)</td>
</tr>
<tr>
<td>2 Council Tax bill valid for current year</td>
</tr>
<tr>
<td>3 Current benefit book or card or original notification letter from Department of Work and Pensions confirming rights to benefits</td>
</tr>
</tbody>
</table>

We can send your documents:

1. Original documents can be sent by special delivery. N.B. if you want the documents returned in this way you must include a pre-paid self-addressed Special Delivery envelope. Otherwise your documents will be returned via normal post.

2. Alternatively you arrange an appointment to bring your documents in by calling 020 3448 8802 Monday to Friday, 10:00 to 16:30. Please do not arrive without making an appointment as there may not be a member of staff available to speak to you.

We appreciate that there are circumstances where it may not be possible to provide original documents either by post or in person. In these instances we may accept good quality certified colour scans of the original.

*If you do not have a document from list A containing your photo please supply a photo of yourself and get someone who has known you (but not a relative) for at least 3 years, to sign the back, ‘I certify that this is a true likeness of …….’ giving their full name with signature and date.