

APPLICATION FOR ACCESS TO DECEASED RECORDS  
IN CONFIDENCE

Please read the Information Notes prior to completing this form in ink using block capitals. On completion return to:

**Access to Health Records Dept, Milton Keynes University Hospital NHS Foundation Trust, Standing Way, Eaglestone, Milton Keynes, MK6 5LD**

**Accesstohealthrecords@mkuh.nhs.uk**

Please fill out the deceased patient’s details below

HOSPITAL NO: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Former/Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Forenames: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Known Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# IS THIS APPLICATION PART OF A COMPLAINT?

YES NO

# WHICH OF THE FOLLOWING DO YOU REQUIRE?

# Medical Records: Yes No Accident & Emergency: Yes No

# 

# X-Rays/Scans/Images: Yes No Blood Test Results: Yes No

**Please Be Aware That X-Rays Will Be On Disc**

**Please state what form you would like your medical notes in:**

Paper copy Disc Email

**(Please note Imaging Discs are compatible with Windows only, emails will be sent encrypted and you will need to call the Access to Health Records office to obtain the password)**

COMMENTS (Please provide any relevant information to help us identify the records you require)

### How would you like to receive your records.

### Collect in Person

Posted

### Please be aware that records can only be posted if we have received photo ID. These will be sent Special Delivery and will require a signature

**DISCLOSURE OF INFORMATION**

Please read the Information Notes prior to completing this form in ink using block capitals.

**CERTIFICATION**

Please fill out your details below

I certify that I am (Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Of (address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide the following forms of ID below in your application:**

1. Access by the executor/Patient representative

* Photo ID
* Proof of address
* Death Certificate
* Proof of executor

1. Claim arising from Estate

* Photo ID
* Proof of address
* Evidence of claim

1. Miscellaneous

* Photo ID
* Proof of address
* Dr to request if medical reason for family history etc.
* Seek permission of IG manager.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

### 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.

**INFORMATION NOTES**

The Access to Health Records Act 1990 gives a deceased patient's personal representative, and anyone who may have a claim arising out of the patient's death, a right of access to the patient’s clinical records. This is not a general right and access may be limited to information of relevance to the possible claim.

**Access can be limited or refused if:**

* There is evidence the patient would not have expected the information would be disclosed to the applicant.
* If the disclosure is likely to cause serious harm to anyone else.
* If it would also disclose information about a third party who does not consent.
* The records contain a note, made at the patient’s request that they did not wish access to be given on an application under this legislation.

The trust will endeavour to deal with your request within a 21-day time limit (NHS best practice). However, by law we have 30 days to respond, if this is likely to take longer the applicant will be warned and an explanation of the delay provided.

Complaints may be forwarded to the Trust’s Information Governance manager at the address below. Alternatively, you can send your complaint directly to the Information Commissioner at Wycliffe House, Water Lane, Wilmslow, SK9 5AF.

When you complete the attached Access to Health Records form, please note that you will be required to provide identification as stated on the request form.

###### Confidentiality

The Trust takes positive action to maintain the confidentiality of its patients’ personal information. Holders of records are obliged by law to be satisfied that an applicant is entitled to access the requested records. This may involve at least identity verification but may, in some circumstances, also require further enquiries to be made.

**Disclosure of Information Form**

Please ensure that you have completed the Disclosure of Information form and that you have signed the Declaration section in ALL cases. If applying on behalf of another person, please ensure the authorization section is also completed.



**Current Charges 2020**

**Providing copies of Patient Health Records**

Free of charge

However, we may charge a ‘reasonable fee’ when a request is manifestly unfounded or excessive, particularly if it is repetitive.

We may also charge a reasonable fee to comply with requests for further copies of the same information.

The fee will be based on the administrative cost of providing the information.

**Viewing records**

Free of charge

An appointment MUST be arranged with the Information Governance Department prior to viewing records electronically.

**Insurance forms**

There is No Charge for officially stamping Insurance forms

Consultant statement/completion is £30.00