University Hospitals of Leicester

NHS Trust

Access to Health Records (AHR) UHL Policy

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1 Introduction

1.1 Provisions made under the sixth principle of the 1998 Data Protection Act allow data subjects the right to access their health records, this is known as 'subject access'. The Access to Health Records Act 1990 has now been repealed, except for the sections dealing with requests to records relating to the deceased.

Under the Data Protection Act 1998, patients have the right to:

- Access their health records, subject to certain safeguards.
- Have copies of their records.
- Have these records explained if they are illegible or unintelligible.

2 Scope and Responsibilities

2.1 Applications under the Data Protection Act 1998 cover paper and computer records. Provisions under the Freedom of Information Act 2000 extend the scope of the Data Protection Act to include unstructured manual files, this will basically give an individual the right of access to any type of personal information held on them.

The main legislative measures that give rights of access to health records include:

The Data Protection Act 1998 – rights for living individuals to access their own records. The right can also be exercised by an authorised representative on the individuals' behalf.

The Access to Health Records Act 1990 – rights of access to deceased patient health records by specified persons.

There is nothing in the Act to prohibit the Healthcare Professional in charge of clinical care to **voluntarily allow patients to see their records** during or at the end of an episode of care, subject to the exemptions outlined. Healthcare Professionals already have the discretion to open records to their patients and the principles underlying the Act encourage these arrangements. Such a request will not constitute an application under the Act. The Trust actively promotes this type of informal access.

Under the Act the obligation to provide access rests with the holder of the record. The Trust is the Data Controller and holder of the records. The holder will provide access only after consultation with the appropriate Healthcare Professional(s) (see appendix 1).

A health record can be recorded in computerised or manual form or in a mixture of both. It may include such things as; hand-written clinical notes, letters to and from other health professionals, laboratory reports, radiographs and other imaging records e.g. X-rays and not just X-ray reports, printouts from monitoring equipment, photographs, videos and tape-recordings of telephone conversations.

The appropriate Healthcare Professional is the practitioner who has clinical responsibility for the particular episode of treatment in the record to which the applicant seeks access. This practitioner may wish to seek the views of other Healthcare Professionals who have had a significant input to the patient's care. If the appropriate Healthcare Professional is not available or has not had clinical responsibility for the patient, the holder would seek the advice of the Healthcare Professional who seems most appropriate to advise on the application.

Applicants do not have to give a reason for requesting access to records**.** The applicant's motives in requesting the records are irrelevant.

Applications should be made to the Access to Health Records department and can be submitted via a completed application form (see appendix 2). An information leaflet accompanies the application form and is also available to send to applicants (see appendix 3).

Requests associated with complaints and/or litigation **must** be processed via the Senior Complaints Officer/Senior Claims Team.

This guideline along with its appendices applies to the Access to Health Records team staff within UHL who process Subject Access Request applications.

3 Access to Healthcare Records Standards

3.1 Living Patient Records

3.1.1 Who has the right to apply?

a. The Patient

b. Any person authorised in writing, to apply on behalf of the patient (see below also)

c. In England and Wales, the person having parental responsibility for a child under 16, or if the record holder feels it is in the child's best interest (see below also). However, where the patient is under age 16 but is mature enough to understand the meaning of the application (termed as being Gillick Competent), the patient can refuse to allow this access.

d. A child (a person under the age of 16 years) who, in the view of the appropriate Healthcare Professional, is capable of understanding what the application is about can prevent a parent from having access to the record. If the child is not capable of understanding the nature of the application, in the view of the appropriate Healthcare Professional, then the holder of the record is entitled to deny access if it would not be in the child's best interest (see below also).

e. Any person appointed by the Court, to manage the affairs of a patient of any age, who is deemed to be incapable (see below also).

f. The applicant must declare that they are entitled to apply for access to the health records referred to. The applicant may also give their authority to a solicitor, or anyone else they choose, to obtain copy records of the patient, on behalf of the applicant.

g. Further enquiries may be needed to confirm the authenticity of applicants other than the patient before access is given. NB proof of identification will be required for access.

If the applicant is acting on the patients behalf then it must be established in what capacity they are making the application:

3.1.2 Records for Patients under the Age of 16

The applicant must have parental responsibility. This will be by way of one of the following:

- The applicant is the child's natural mother (and there is no Residents Order or other Court Order to the contrary). We have to take the applicants / Solicitors written word for this at face value. This is often referred to as *acting in loco parentis* and is where the patient is under age 16 and is incapable of understanding the request.

- Also, where the patient is under age 16 but is mature enough to understand the meaning of the application and giving authority (termed as being Gillick Competent) and has consented to the applicant making this request, the authorisation of the patient and / or mother should be given. Again, we have to take the applicants / Solicitors written word for this at face value.

- The applicant is the child's natural father and was married to the child's natural mother at the time of conception or birth of the child or subsequently marries the mother at a later stage. NB the father does not necessarily still have to be married to the child's natural mother. He could be legally separated or divorced from her. Also, this whole point only applies providing that there is no Residents Order or other Court Order to the contrary. We can accept a Solicitor's written confirmation of this. Marriage / Divorce papers are not necessary.

- The applicant is the child's natural father but was not married to the child's natural mother at the time of conception or birth of the child, but there is an agreement between both parents, which has been passed by a Court of Law. Documentation will exist if this is the case, and a photocopy of it should be obtained.

- The applicant has parental responsibility by way of a Court Order. This would be by way of a Parental Responsibility Order or Residence Order. This could apply to the child's natural father, a grandparent or other relative. A care order in favour of Social Services grants parental responsibility to a Local Authority. Documentation will exist if this is the case, and a photocopy of it should be obtained.

- For any child whose birth is registered on or after 1st December 2003 then if the father's name is recorded on the child's birth certificate the father will automatically have parental responsibility.

- A range of other people may acquire Parental Responsibility by a court order, e.g. step-parents, grandparents. A 'second parent' in a same-sex relationship will have Parental Responsibility where she/he is named on the birth certificate.

- There is no limit on the number of people who can have Parental Responsibility at the same time and nobody loses it just because another person gains it.

- Female Civil Partners will both automatically acquire Parental Responsibility if they are in a civil partnership at the point of conception which must be by donor insemination.

- A Local Authority will acquire Parental Responsibility where it obtains either an Emergency Protection Order or a Care Order in respect of a Child until the Order is terminated at which point Parental Responsibility ceases.

- If the applicant does not satisfy any of the above criteria, then access to the records will be denied, unless the applicant can provide the written authority of someone who has got parental responsibility. Living with the mother, even for a long time, does not give a father parental responsibility and if the parents are not married, parental responsibility does not automatically always pass to the natural father if the mother dies.

3.1.3 Records for Patients over the Age of 16

Patients capable of managing their own affairs - the applicant must have the written authority of the patient if the patient is capable of managing their own affairs.

Patients incapable of managing their own affairs - the applicant must have proof that they have the authority to act on behalf of the patient. This will be by way of one of the following:

- They have been appointed by the Court to manage the patient's affairs. Documentation will exist if this is the case, and a photocopy of it should be obtained.

- They are the deceased patient's personal representative. Documentation will exist if this is the case, and a photocopy of it should be obtained.

3.1.4 Other Considerations for All Records for Patients of Any Age

Healthcare Professional has also got the discretion not to release records to an applicant if they consider it to be in the best interests of the patient at that time. They would be responsible for their clinical judgement.

The only other over riding rule would be where a court order required disclosure of the medical records in question to the applicant. In these circumstances advice should be sought from Legal Services so that consideration could be given to seeking revocation of the court order so as to protect a patient's rights.

There are also a range of public bodies that have lawful authority to require the disclosure of health information. These include the Courts, legally constituted Public Inquiries and various regulators and Commissions e.g. the Audit Commission and the Care Quality Commission, in these cases the common law obligation to confidentiality is overridden.

3.2 Deceased Patient Records

3.2.1 The Access to Health Records Act (AHRA) 1990

The AHRA provides certain individuals with a right of access to the health records of a deceased individual. These individuals are defined under section 3 (1)(f) of that Act as, 'the patients personal representative and any person who may have a claim arising out of the patients death'. A personal representative is the executor or administrator of the deceased personal estate.

3.2.2 Identity

Record holders must satisfy themselves as to the identity of the applicants who should provide as much information to identify themselves as possible. Where an application is being made on the basis of a claim arising from the deceased's death, applicants must provide evidence to support their claim. Personal representatives will also need to provide evidence of identity.

3.2.3 Requests

A request for access should be made in writing to the record holder ensuring that it contains sufficient information to enable the correct records to be identified. Applicants may wish to specify particular dates or parts of records which they wish to access. This may help reduce the fee that is payable for copies provided. The request should also give details of the applicants' right to access the records.

3.2.4 Timescales

Once the data controller has the relevant information and fee, they should comply with the request promptly and within 21 days where the record has been added to in the last 40 days, and within 40 days otherwise.

3.2.5 Exemptions to disclosures of information relating to deceased patients

Where a patient has died, access should not be given to information**,** which in the opinion of the holder is not relevant to any claim arising out of the death. Also, if the patient has died and the record includes a note made at the patients request that he/she did not wish access to be given to their personal representative or to any person having a claim arising from their death, access will be refused.

In addition, the record holder has the right to deny or restrict access to the record if it is felt that:

- Disclosure would cause serious harm to the physical or mental health of any other person

- Or would identify a third person, who has not consented to the release of that information

3.2.6 Disclosure in the absence of a statutory basis

Disclosures in the absence of a statutory basis should be in the public interest, be proportionate and judged on a case by case basis. The public good that would be served by disclosure must outweigh both the obligation of confidentiality owed to the deceased individual, any other individuals referenced in a record, and the overall importance placed in the health service providing a confidential service. Key issues for consideration include any preference expressed by the deceased prior to death, the distress or detriment that any living individual might suffer following the disclosure, and any loss of privacy that might result and the impact upon the reputation of the deceased. The views of surviving family and the length of time after death are also important considerations. The obligation and confidentiality to the deceased is likely to be less than that owed to living patients and will diminish over time.

Another important consideration is the extent of the disclosure. Disclosing a complete health record is likely to require a stronger justification than a partial disclosure of information abstracted from the record. If the point of interest is the latest clinical episode or cause of death, then disclosure, where this is judged appropriate, should be limited to the pertinent details.

This guidance is not intended to support or facilitate open access to the health records of the deceased. Individuals requesting access to deceased patient health information should be able to demonstrate a legitimate purpose, generally a strong public interest justification and in many cases a legitimate relationship to the deceased patient. On making a request for information, the requestor should be asked to provide authenticating details to prove their identity and their relationship with the deceased individual. They should also provide a reason for the request and where possible, specify the parts of the deceased health records they require.

Relative, friends and carers may have a range of important reasons for requesting information about deceased patients. For example, helping a relative understand the cause of death and actions taken to ease suffering of the patient at the time may help aid the bereavement process, or providing living relatives with genetic information about a hereditary condition may improve the health outcomes for the surviving relatives of the deceased.

In some cases the decision about disclosure may not be simple or straightforward and a senior lead on patient confidentiality, for example the organisations Caldicott Guardian or Information Governance lead should be consulted. In the most complex cases it may be necessary to seek advice from Steve Murray, Assistant Director of Legal Services.

3.2.7 Receiving access requests under the Data Protection Act (DPA)

A request for access to health records in accordance with DPA (the DPA refers to these as a subject access request) should be made in writing to the data controller. However, where an individual is unable to make a written request it is the Department of Health view that in serving the interest of patients it can be made verbally, with the details recorded on the individuals file.

The requestor should provide enough proof to satisfy the data controller of their identity and to enable the data controller to locate the information required. If this information is not contained in the original request the data controller should seek proof as required. Where requests are made on behalf of the individual patient the data controller should be satisfied that the individual has given consent to release their information

As good practice the data controller may check with the applicant whether all or just some of the information contained in the health record is required before processing the request. This may decrease the cost for the applicant and eliminate unnecessary work by NHS staff. However, there is no requirement under the Act for the applicant to inform the data controller which parts of the records they require.

Where an access request has previously been met the Act permits that a subsequent identical or similar request does not have to be fulfilled unless a reasonable time interval has elapsed between. For Trust purposes and in line with Freedom of Information standards this is defined as 2 request per annum (unless exceptional circumstances are noted)

4 Appropriate health professional to consult

4.1 The Data Protection (subject access modification) (health) order 2000 sets out the appropriate health professional to be consulted to assist with subject access requests as the following:

- The health professional (see appendix 4) who is currently, or was most recently, responsible for the clinical care of the data subject in connection with the information which is the subject of the request; or

- Where there is more than one such health professional, the health professional who is the most suitable to advise on the information which is the subject of the request.

5 When Access to Records may be denied or partially excluded

5.1 Withheld information

Within the Act there is provision for some information to be withheld:

- The patient does not have to be told that information has been withheld because that in itself could be damaging to them.

- The patient is not, however, prevented from asking the practitioner whether the full record has been made available, and may apply to the Courts if they are dissatisfied with the answer.

- The fact that a record has not been prepared in anticipation that it might be accessed is no justification for denying access. Also, fear of legal action is not a reason for denying access.

Healthcare Professionals are advised that records should be compiled on the assumption that they will be accessible to patients and / or the Courts.

5.2 Access shall not be given unless the holder is satisfied that the applicant is capable of understanding the nature of the application and the meaning of the authorisation.

5.3 Where **a patient has died**, access should not be given to information, which in the opinion of the holder is not relevant to any claim arising out of the death. Also, if the patient has died and the record includes a note made at the patient's request that he / she did not wish access to be given to their personal representative or to any person having a claim arising from their death, access will be refused.

5.4 If in the opinion of the holder of the record, the information may cause serious harm to the physical and / or mental health of the patient and whether access would be in the best interests or wishes of the patient, access shall not be given.

Access to Health Records would not disclose information relating to or provided by a third person who has not consented to that disclosure **unless:**

- The third party is a health professional who has complied or contributed to the health records or who has been involved in the care of the patient.
- The third party, who is not a health professional, gives their consent to the disclosure of that information
- It is reasonable to disclose without that third party's consent

5.5 Where information that is adjudged to be harmful is withheld, an appointment should be made for the applicant to inspect the remainder of the record with the Healthcare Professional.

6 Patients living abroad requiring access to their health records

6.1 Former patients living outside of the UK who had treatment in the UK have the same rights under the DPA to apply for access to their UK health records. An NHS organisation should treat these requests the same as someone making an access request from within the UK.

6.2 Original Health Records should not be given to patients to keep. In instances when a patient moves abroad the UK GP may be prepared to provide the patient with a summary of their treatment. Alternatively the patient is entitled to make a request for access to their health records under the DPA to obtain copies.

7 Requests for personal data other than medical records

7.1 An individual may ask for personal data other than medical records that the Trust holds on them. This could include the new category of unstructured manual data held by public authorities as created by the Freedom of Information Act 2000.

7.2 Such applications may include requests for copies of incident report forms, minutes of meetings where they were discussed, emails relating to them and any other reports or correspondence of which they are the subject.

7.3 Any request for non-personal information that does not relate to the requestor (or the individual they are making the request on the behalf of) should be treated as a request under the Freedom of Information Act and forwarded to Trust Administration to process.

7.4 Where the request is for a combination of personal and non-personal data, the Access to Health Records department should liaise with Trust Administration to ensure a combined response. For further information see the UHL 'Freedom of Information Act 2000 and Environmental Information Regulations Policy'.

7.5 Where an individual requests access to unstructured manual personal data, the Trust can ask the individual for further information in order that this data can be located.

7.6 Any requests for other types of non-personal data will be sent to the Freedom of Information Lead within the CMG(s) concerned to collate. Once collated this data should be returned to the Access to Health Records Officer dealing with the case and reviewed by the Information Governance Manager before being dispatched.

8 Informal access, sharing of information

8.1 Where all conditions outlined above are met, informal access from patients should be encouraged during the period of their care. As we move into a period of openness within the NHS, the more the information that we hold should be actively shared with patients. This will have a positive effect on the accuracy of health records and will aid patient recall of their consultation.

8.2 The 'copying letters to patients' project, provides patients the right to a copy of any correspondence about them sent between two health professionals, will also enhance this process. A patient may not want to receive a copy of a letter at the time that it is written; they will however retain the right of access to that letter at any point in the future.

9 Time Limits for Access

9.1 The Act imposes very specific duties upon us, which have to be carried out within a very tight timescale.

From receipt of the application form, **14 days are allowed if the record holder needs more information**, either to identify the record(s) asked for, or to check the identity of the person applying for access.

9.2 After that **the Trust** will endeavour to comply with subject access requests within 21 days where reasonably possible, and in any case within the 40 days specified in the Data Protection Act 1998.

Failure to comply gives the applicant a right of action in the County Court or High Court. It is therefore essential that all applications be processed as a matter of priority, thereby minimising risk to the organisation.

10 Where Staff Request Access

10.1 Members of UHL staff should go through the standard procedure for accessing their own health records.

10.2 On no account should staff attempt to access their own records or those of friends or family members or anyone else without a legitimate business reason. This includes any information held electronically. Staff members found to be doing so without a legitimate business purpose will be subject to the Trust's disciplinary procedure.

11 Access to Health Records Charging Structure

11.1 Fee structure

The following fee structure is based on guidance from the Department of Health [1] and a comparison against other Trusts. It is intended to ensure that charging is applied consistently and equitably and cannot be perceived as imposing a restriction on the ability of individuals to gain access to information to which they are legitimately entitled.

[1] Guidance for Access to Health Records Requests under the Data Protection Act 1998 – June 2003

	Record Type	Fee
Viewings	< 40 days	£0
	>40 days	£10
Electronic Results	All	£10
Photocopies	Core Notes inc X-Rays	£50
	A&E Notes	£25
	A&E Notes + X-Rays	£50
Photocopies for Deceased patient records	All	£10 admin fee + cost of making the copies @ 35p per sheet + p&p

Nil Charge for viewings, where records have been added to within the 40 days preceding the request.

Fixed £10 charge for other viewings & copies of results held electronically.

Reduced fee of £25 for A&E notes due to their smaller size

Maximum £50 charge for all other case notes inclusive of x-rays other than for deceased patient records where there is no maximum fee as per the Access to Health Records Act

A maximum of two requests for an update to information previously provided, within 365 days, will be treated as a continuation of the original request and incur no additional charge. Requests for an update to information previously provided, outside 365 days or more than twice within 365 days, will be treated as a new request with an additional fee.

An individual or their representative may make a number of "reasonable" requests to the same information. For Trust purposes and in line with Freedom of Information standards this is defined as 2 requests per annum (unless exceptional circumstances are noted).

Where only a portion of the record is requested the Access to Health Records Manager may exercise discretion in the amount charged.

Note: if a person wishes to view their health records and then wants to be provided with copies this would still come under the one access request. The £10 maximum fee for viewing would be included within the fee for copies of the health records.

Where the information is not readily available to the patient, an explanation (e.g. of abbreviations or medical terminology) must be given.

11.2 Viewing Health Records

If it is agreed that the patient or their representative may directly inspect their health records, it should be considered whether access should be supervised by a health professional or a lay administrator. A lay administrator is a neutral person who can oversee the viewing and ensure that the records remain safe. In these circumstances the lay administrator must not comment or advise on the content of the record. If the applicant raises queries an appointment with a health professional should be offered. The lay administrator would ordinarily be a staff member from the Access to Health Records team.

12 Amendments to health records

12.1 If the applicant considers that there are mistakes or inaccuracies in the record they can ask the record holder for a note to be made in the records stating their opinion. If the health professional agrees that the information is inaccurate, he / she should make the correction. Care must be taken not to simply obliterate information, which may have significance for the future care and treatment of the patient, or for litigation purposes.

12.2 Where the health professional and patient disagree about the accuracy of the entry, the Department of Health recommends that the data controller should allow the patient to include a statement within their record to the effect that they disagree with the content.

It should be understood that in Law nothing may be erased from a paper health record but a correction may be added.

12.3 If the patient is unhappy with the outcomes outlined in paragraphs 12.1 to 12.2, there is the option of taking this more formally (see complaints in section 13)

12.4 A copy of any correction or note should be supplied to the patient. No fee may be charged for this.

13 Complaints Concerning Application

13.1 If the applicant feels that they have not been fairly treated and that the holder of the record has not complied with the Act, then they should first complain through the normal UHL complaints procedure.

In the first instance, the health professional involved should arrange to have an informal meeting with the individual to try and resolve the complaint locally.

If the issue remains unresolved, the patient should be informed that they have a right to make a complaint through the NHS complaints procedure. Further information is available at:

http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx

Ultimately, the patient may not wish to make a complaint through the NHS Complaints Procedure and take their complaint direct to the Information Commissioners office, if they believe the NHS is not complying with their request in accordance with the Data Protection Act or Access to Health Records Act.

Alternatively, if the patient wishes to do so, they may wish to seek legal independent advice.

14 Additional Information

14.1 Under the Access to Medical Reports Act 1988, individuals can apply to access to medical reports prepared for employment or insurance purposes.

In most cases access under the Act will be straightforward. However, there will be instances where a detailed knowledge of the Act and its implications are vital.

14.2 The Information Commissioners website also provides some useful information.

http://www.ico.org.uk

Any further advice should be directed to the Information Governance Manager or Corporate & Legal Affairs.

15 Designated Responsible Officer

15.1 The person responsible for the operation, monitoring and review of this guideline is the Healthcare Records Service Manager. The Healthcare Records Service Manager in conjunction with the Trust's Head of Privacy will also be responsible for keeping relevant staff groups up-to-date with the latest subject access developments.

16 Advice and Guidance

16.1 For further advice and guidance on making an application under the Access to Health Records Act or the Data Protection Act please contact the Access to Healthcare Records Supervisor at the Leicester Royal Infirmary on 2047939. For further advice or guidance on the disclosure of information, please contact either the Head of Privacy or the Assistant Director of Corporate and Legal Affairs. Further information and contact details can be found at the 'Information Governance' section of the UHL intranet.

17 Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Percentage of SARs closed within 40 day timescale	Ongoing statistics collated and reported via Trust scorecard	Monthly	Access to Health Supervisor / Service Manager

18 Legal Liability Guideline Statement

Guidelines or Procedures issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines or Procedures and always only providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional' it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes

19 Key Words

Access to Health Records, Health Records, Medical Records, Data Protection Act, DPA, Subject Access Request, SAR, Records, Freedom of Information, FOI, Information Governance, Privacy

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DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT			
Author / Lead Officer:	Jo Lowry	**Job Title:** Healthcare Records Governance & Service Manager	
Reviewed by:	Jo Lowry		
Approved by:	**PGC Committee**	**Date Approved: 18th March 2016**	

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
21/03/2003	**1.0**	**M. Edwards**	
27/06/2003	**1.1**	**J. Henderson**	
13/08/2003	**1.2**	**N/A**	
28/06/2004	**1.3**	**J. Henderson**	
07/03/2005	**1.4**	**J. Henderson**	
06/01/2006	**1.5**	**J. Henderson**	
13/03/2006	**1.6**	**PGC/ J. Henderson**	
16/04/2007	**1.7**	**D. Waters**	
08/05/2007	**1.7**	**Approved PGC**	
07/09/2010	**1.8**	**Cathy Lea**	
17/09/2012	**1.9**	**Debbie Waters**	
06/12/2013	**1.10**	**Jo Lowry**	Review and transfer to UHL Guideline template
09/03/2016	**1.11**	**Jo Lowry / Lisa Beattie**	Review and minor updates

DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**
April 2016	Access to Health Records staff	Access to Health Records	
April 2016	Ewan Robson	Privacy Team	
April 2016	Steve Murray	Legal Services	

Appendix 1 – Permission from Health Professional for release of Health Records

PERMISSION FROM HEALTH PROFESSIONAL FOR RELEASE OF HEALTH RECORDS

Note for secretaries: In the event of the named recipient being unavailable, please pass on to an appropriate deputy for completion.

Name of Hospital, dept address **From: Staff Name**
Access to Health Records Dept **Ext:**
Date
Our ref:

Data Protection Act 1998/Access to Health Records Act 1990 Application for release of Health Records

Patient: **DoB:**

To: Practitioner Name

The above patient/representative or their solicitor has applied for access to his/her medical notes.
Under the 1998 Data Protection Act/1990 Access to Health Records Act, a health professional is required to check that releasing the notes would not cause serious mental or physical harm to the patient or anyone applying for access to the records.

Please, therefore could you read the attached notes and complete the slip below

Please return the form and copies by (date) to (staff name) at the above address.

In my opinion, release of these notes would not cause serious mental or physical harm to the patient or any other individual.	☐

In my opinion, release of these notes would cause serious mental or physical harm to the patient or any other individual because:-

Signed	**Date**

Appendix 2 – Application form for Access to Health Records

Application for access to health records held by the University Hospitals of Leicester NHS Trust

Please read the information sheet before completing this form

PATIENT'S DETAILS (records to be accessed)	
Patient's title (Mr/Mrs/Miss)	
Patient's full name	
Date of Birth	
	Living ☐ **Deceased** ☐ **Please see guidance notes for applicable legislative acts, fees and documentation required**
Address **Postcode**	
Telephone number	
Hospital no (if known)	
Email address (so we can send you a password)	

RECORDS REQUIRED	
Details of records required please be specific e.g. department attended, consultant's name	

Dates of records required **e.g. accident date**	
Hospital records required	**Leicester Royal Infirmary** **Leicester General Hospital** **(delete as appropriate)** **Glenfield Hospital**
I wish to:	**Have photocopies of the records** OR **(delete as appropriate)** **Have a copy of the records on CD**
Do you require copies of x-rays?	**YES/NO** **(delete as appropriate)**

APPLICANT'S DETAILS (if different from the patient)	
Full name (including title)	
Address **Postcode**	
Telephone number	

DECLARATION (please tick one of the following boxes):	
I am the patient	
I have been asked to act by the patient and I attach the patient's written authorisation	
I have full parental responsibility for the patient and the patient is under the age of 16 and: (a) has consented to my making this request or (b) is incapable of understanding the request (delete as appropriate)	
I have been appointed by the court to manage the patient's affairs and I attach a certified copy of the court order appointing me to do so	

I have a claim arising from the patient's death and wish to access information relevant to my claim **(supporting documentation must be provided e.g. copy of the deceased's Will naming you as executor along with proof of your ID and address OR a letter proving the claim from a Legal representative)**	

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 1998 and the Access to Health Records Act 1990

APPLICANT'S SIGNATURE: ..... DATE: .....

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

Before returning this form please ensure that you have:
a) signed and dated this form
b) enclosed proof of your identity
c) enclosed the correct fee (if applicable)
d) enclosed documentation to support your request (if applying for another person's records)

Please send the completed form and documentation to:

Access to Health Records
(option 3)
Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Tel No: 0300 3031563
Fax No: 0116 2047925
Email: ahrlri@uhl-tr.nhs.uk

Appendix 3 – A Guide for Applicants

Access to Health Records

A guide for applicants

This guide will explain how to access Copies of medical records from the University Hospitals of Leicester NHS Trust which includes:

- **Leicester Royal Infirmary**
- **Leicester General Hospital**
- **Glenfield Hospital**

Records for the Urgent Care Centre and other Leicester, Leicestershire and Rutland hospitals need to be applied for directly to them and a separate application submitted – details of useful contacts are recorded at the end of this booklet.

Who can apply to access medical records?

- the patient
- another person (with the patient's written permission)
- a parent or guardian of a person under 16 (where a child is considered capable of making decisions about his/her medical treatment, the consent of the child must be sought before a person with parental responsibility can be given access)
- a court appointed representative of someone who is unable to manage their own affairs
- where the patient has died, the executor as named on the will or anyone having a claim resulting from the death may apply to see the records or part of them

Can I see all of my medical records?

- a Health Care Professional can restrict access to information which may cause serious harm to your mental or physical health
- information may be withheld if the patient has asked for it not to be disclosed
- old records may have been destroyed in accordance with Trust policy
- records which identify or relate to another person will not be disclosed

What are the fees for access?

If you require copies of records supplied under the Data Protection Act 1998 (which covers the records of living individuals) the charges are as follows:

£10 computer records only (e.g. test results/blood group/attendance dates)

£25 A&E records

£50 other hospital records

£50 x-rays and records

£10 x-rays only (on cd)

Charges for viewing medical record files

£10 patients wishing to view records who have not attended the hospital in the last 40 days

No fee patients wishing to view records who have attended the hospital in the last 40 days

If you require more than one set of A&E records the charge will be £50. If you require records from more than one hospital within the Trust you will not be charged more than £50.

The maximum charge is £50 for the records of living individuals under the terms of the Data Protection Act.

Charges for a deceased patient's records:

Applications concerning a deceased patient's medical records will be dealt with under the Access to Health Records Act 1990.

The total cost for copies of a deceased patient's records will not be known until the records are scanned. As soon as we have calculated the cost we will contact you to request payment. We require payment before we can post the records to you.

There will be a £10 administration fee plus a 35p per page reproduction charge and a charge for postage (CD only = £3.50 postage). The document is reproduced via the same process whether the output is to printed paper or onto a CD.

In accordance with the Access to Health Records Act there is no maximum fee.

How do I pay for the records?

We accept payment by cheque, postal order or payment by card (via the cashiers office 0116 258 5175).
Please do not send cash.

Cheques should be made payable to 'University Hospitals of Leicester NHS Trust'.

Unfortunately fees cannot be waivered in any circumstance.

What proof of identity do I need to provide?

If you are applying for copies of your own records you will need to send proof of your identity.

Please send a **copy** of:

- Current passport
- **OR** full driving licence
- **OR** birth certificate – where name has changed then additional proof is required e.g. marriage certificate / change of name deed)

  – If applying for a child's record then a **FULL birth certificate** is required naming the parent/s

- **AND** a copy of a current utility bill or bank statement to verify your current address

Additional documents that may be acceptable are:

- Disability Blue Badge
- Bank Card with a supporting statement
- Other Photo ID considered

Please do not send original documents.

If you are applying for records on behalf of the patient you will need to provide proof of your identity (as above) and also include the patient's written authorisation for you to have access to their records as well as proof of their identity.

If you are applying for the records of a deceased individual you must include proof of your own identity together with proof of your appointment as executor or administrator (e.g. a copy of the will).

If you have a claim arising from the patient's death you are required to send documentary evidence to support this e.g. copy of the deceased's will naming you as executor along with proof of your ID and address OR a letter proving the claim from a Legal representative.

What will happen after I apply?

When the department has received the completed application form the validity of the request is checked to ensure that the person applying has the right to apply – particularly if applying for another person's records.

The relevant medical records are then obtained and either photocopied or scanned. The records will then be passed to the appropriate clinicians for permission to release the copies you require.

If access is granted the records will be posted to you by recorded delivery.
Please advise us on the application form whether you would prefer to receive photocopies of your records or receive them on a cd. The cd will be encrypted with a password which will be given to you separately. If you would like to receive your password by email please include your email address on the application form. To be able to view the information on the cd please ensure you have Adobe Reader X (Version 10) installed on your computer. This is a free download.

How long will it take?

We aim to make your records available to you within 40 days of receiving your fully completed request, proof of your identity and the fee (if applicable).

Who do I contact if I have any questions?

If you have any questions you can contact the Access to Health Records team at the address below:

Access to Health Records
Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW
Tel: 0300 3031563 (option 3)
Fax: 0116 2047925
Email: ahrlri@uhl-tr.nhs.uk

If for any reason you are dissatisfied with our service and wish to make a formal complaint then please contact the:

Patient Information and Liaison Service (PILS)
The Firs
c/o The Glenfield Hospital
Groby Road
Leicester
LE3 9QP
Freephone: 0808 178 8337
Fax: 0116 258 8661
Email: pils@uhl-tr.nhs.uk

Useful Contacts

GP Records
Central Registrations
Gwendolen House
Coleman Road
LE5 4PW
Tel: 0116 2957880

Urgent Care Centre
Admin Office
Leicester Royal Infirmary
LE1 5WW
Tel: 0116 2957200

Mental Health Services
Leicestershire Partnership NHS Trust
Riverside House
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8PQ
Tel: 0116 295 1350

Requests for other non-UHL Hospital Records please contact the relevant hospital you attended.

Please keep this guide for your information

Appendix 4 – Access to Health Records definitions

Access to Health Records definitions

There are certain definitions given in the Act. These are:

An **Application** means an application in writing (see subject access procedure in Appendix 5)

A **Health Record** is defined as information relating to the physical and/or mental health individual who can be identified from that information and which has been made by, or on behalf of a Healthcare Professional, in connection with the care of that individual.

The **Holder** of the record is the health service body by which, or on whose behalf, the record is held.

The **Patient** is the individual in connection with whose care the record has been made.

The **Healthcare Professional** can be one or more of the following registered professions:

- Medical Practitioner
- Dentist
- Optician
- Pharmaceutical Chemist
- Nurse
- Midwife
- Health Visitor
- Osteopath
- Chiropractor
- Podiatrist
- Dietician
- Occupational Therapist
- Orthoptist
- Physiotherapist
- Clinical Psychologist
- Child Psycotherapist
- Speech Therapist
- An art or music therapist employed by the Health Service
- Any other registered member of a profession supplementary to the Medicines Act 1960
- A scientist employed by the Health Service as a head of department

Appendix 5 – UHL Subject Access Procedure

UHL Subject Access Procedure

Requests should be sent to the Access to Health Records Department

Requests for access:

If a patient telephones or writes to the Trust to request access to records, an application form should be sent to them.
We do not process requests without a completed form and proof of identity.

Where applications include requests for personal data other than medical records this section should be passed to the Freedom of Information Lead for the CMG(s) concerned to collate (see section 5). This data should then be returned to the Access to Health Records Officer dealing with the case and reviewed by the Information Governance Manager before being sent to the individual.

New Applications

i) When taking on new applications make sure that each has a form of authority signed by the patient or if the patient is under 16, signed by the parent or guardian.

ii) If the request is for a deceased patient from the patient's personal representative there should be legal documentation to support their instruction or someone who has a claim arising from the patient's death should give relevant information to support their request.

If you suspect fraud

If for whatever reason you are suspicious of a subject access request, contact the Information Governance Manager immediately who will inform the police.

Disproportionate effort

You may decline to provide a copy of personal data in permanent form if supplying it would require 'disproportionate effort'. This might apply if the printed version of the data is very lengthy and/or has to be retrieved from a remote archive. Cost should not be factor in the decision. However, you cannot withhold personal data on a data subject on the grounds of disproportionate effort.

You can however withhold the data in a particular permanent form. You may be unable to supply a copy in permanent form, but must offer to supply the data in another form (e.g. let the subject come in and view their data).

The decision as to whether disproportionate effort can be legitimately claimed for an access request must be judged on each individual case.

Obtaining consent

Copy records are sent for consent to the consultant in charge of the patient's treatment e.g.

Access may not be permitted if any of the following circumstances apply:

- If access would be likely to cause serious harm to the physical or mental health of the patient
- Access would disclose information relating to an individual other than the patient who could be identified by that information

If the consultant has refused to give their consent the applicant must be informed in writing. If the applicant wishes to challenge this they can write to: Team 1, Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

Photographs

Copy photographs are requested by email to the Medical Illustrations department.

If the applicant requires photographs only, then the request can be forwarded to Medical Illustrations for them to deal with directly.

Viewing records with Access to Health Records staff

The applicant may state on their application form that they only want to view their records.

Once consent has been received from the consultant in charge of the patient's treatment we can contact the patient to arrange a time to come in and view the records.

The fee for viewing records is £10, which can be paid by cheque when the patient comes into the department or an invoice can be raised.

Requests for rectification, blocking, erasure or destruction

If, after receiving their notes, the subject objects to or disagrees with any part of them, they can request that they be rectified, blocked, erased or destroyed.

Such a request must be made in writing, outlining their areas of concern. Any person making a telephone enquiry should be directed to put their request in writing. Once the letter is received, the date it was received and the nature of the request should again be entered onto the AHR database.

The Head of Privacy should review the letter. If the letter outlines any complaints, then the case should be passed to the complaints department. If the letter outlines any legal action against the Trust, the case must be processed via the Senior Complaints Officer/Senior Claims Team as appropriate. A copy of the letter should be added to the relevant notes of the individual.

A letter of acknowledgement should be sent to the patient, stating the next course of action.
Either;

If the objection is not deemed a matter for complaints or litigation, a copy of the objection will be sent to the relevant consultant who will review the case and contact the patient directly to review the matter.
Or;

If the objection is deemed a matter for complaints or litigation
Inform the patient that their letter has been passed on to complaints or litigation and they will be contacting the patient directly to review the matter.