

**Application for access to records under the General Data Protection Regulations 2018, the subject access provisions of the Data Protection Act 2018 and the**

**Access to Health Records Act 1990**

Leicestershire Partnership NHS Trust provides integrated mental health, learning disability and community health services in a variety of settings. To help us locate the health records you require please provide as much information as possible.

Section A– Information about the person whose health records are being requested, i.e. the data subject.

|  |  |
| --- | --- |
| **Name:** |  |
|  |  |
| **Any other name(s) known by:**  *(For example previous surnames, or names the patient preferred to be known as).* |  |
|  |  |
| **Current home address:**  *(with postcode)* |  |
|  |  |
| **Day time telephone number:** |  |
|  |  |
| **Previous address (if applicable)** |  |
|  |  |
| **Date of birth:** |  |
|  |  |
| **NHS Number:** *(if known)* |  |
|  |  |
| **Hospital numbers:** *(if known)* |  |
|  |  |
| **Please give any information about the health records you require, including services, locations and dates:** |  |

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|  |  |
| --- | --- |
| **Any other additional relevant information:** |  |

**Section B – to be completed by the person making the request**

I declare that the information in this form is correct to the best of my knowledge and that: (*please tick and complete the information requested)*

* **I am the data subject (the person whose records are being requested)**
* **I have been asked to make this application by the data subject**

*(You will also be required to confirm your legal entitlement to access*

*the records, e.g. consent from the data subject)*

* **The patient is under 13 years of age and I am acting in loco parentis**
* **The person is deceased**

*(You will also be required to confirm your legal entitlement to access*

*the records, e.g. personal representative of the deceased or you have a*

*claim arising out of the death)*

|  |  |
| --- | --- |
| **Name of person making the request:** |  |
|  |  |
| **Email address:**  *(if you are happy to be contacted by email),* **or**  **Postal address:** (with postcode) |  |
|  |  |
| **Day time telephone number:** |  |

**Signed:** ……………………………………………………. **Date**: ………………………………….

**The completed application form should be returned to:**

**Data Privacy Team**

**Leicestershire Partnership NHS Trust**

**Room 500 Rutland Building**

**County Hall**

**Leicester Road**

**Glenfield**

**Leicestershire**

**LE3 8RA**

If you have any queries, please contact the team:

Email: [lpt.sarrequests@nhs.net](mailto:lpt.sarrequests@nhs.net)

*Please do not email personal information until a secure email account has been set up with you.*

Further information can be found at:

<https://www.leicspart.nhs.uk/about/requesting-your-record/>