IN CONFIDENCE

**IMAGING DEPARTMENT**

###### APPLICATION FOR COPY XRAYS/SCANS UNDER THE

**GENERAL DATA PROTECTION REGULATION (GDPR)**

**COMPLETE IN BLOCK CAPITALS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARTICULARS OF PERSON WHOSE INFORMATION IS REQUESTED**

Surname................................................................ Forename(s)........................................................................

Hospital No.......................................................... Date of Birth....................................... Sex....................

Address.......................................................................................................................................................................

....................................................................................................................................................................................

........................................................ Postcode...................................... Telephone No...............................................

Email:…………………………………………….………………………….. Mobile No………..…….………………………

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

|  |  |  |  |
| --- | --- | --- | --- |
| Previous Surname (1) | .................................................................. | (2) | .................................................................. |
|  |  |  |  |
| Previous Address | .................................................................. |  | .................................................................. |
|  |  |  |  |
|  | .................................................................. |  | .................................................................. |
|  |  |  |  |
|  | .................................................................. |  | .................................................................. |
|  |  |  |  |
| Date of Change | .................................................................. |  | .................................................................. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE GIVE DETAILS OF THE EPISODES OF TREATMENT FOR WHICH ACCESS TO INFORMATION IS REQUESTED.**

Please provide as much information as possible. Give full details of all episodes you are interested in and if you only wish to receive data relating to a specific aspect of one or other of these episodes, please specify in the comments section below.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Hospital** |  | **Dates** |  | **Ward or Outpatient Clinic** |  | **Consultant** |
|  |  |  |  |  |  |  |  |
| 1. | ………………………. |  | …………………….. |  | ……………………………… |  | …………………………. |
|  |  |  |  |  |  |  |  |
| 2. | ………………………. |  | …………………….. |  | ……………………………… |  | …………………………. |
|  |  |  |  |  |  |  |  |
| 3. | ………………………. |  | …………………….. |  | ……………………………… |  | …………………………. |
|  |  |  |  |  |  |  |  |
| 4. | ………………………. |  | …………………….. |  | ……………………………… |  | …………………………. |

Other information requested (please give details).......................................................................................................……

.............................................................................…….............................................................................................……….

**DECLARATION**

I declare that the information given in this form is correct, to the best of my knowledge and that:

\* I am the person named overleaf.

\* I am acting on behalf of the person named overleaf.

\* I am the guardian of the patient who is a child and (is incapable of understanding the request)

\* I am the deceased patient's personal representative and attach confirmation of my appointment.

\* I have a claim arising from the patient's death and wish to access information relevant to my claim and

 attach supporting documentation from the personal representative.

(\*Delete as appropriate)

I understand that under the General Data Protection Regulation (GDPR) there is no charge for my Imaging.

Signature of Applicant:………………………………………………. Date:………………………………..

**NOTE**

a. If you are acting on behalf of another person, Part 1 of the "Authorisation" section below must be completed.

b. In the case of the patient being a child, Part 2 of the "Authorisation" section below must also be completed**.**

Applicants Name......................................................... Address to which a reply should be sent

(**Print in Capitals**) (**if different from that specified overleaf**)

 ..................................................................................

 ..................................................................................

Signature of Applicant................................................. Date..............................................................

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORISATION**

Part 1 (on behalf of another person)

I hereby authorise Imperial College Healthcare NHS Trust to release any personal information they may hold relating to me to:........................................................................(**name of the person acting on your** **behalf).**

Signature................................................................ Date.........................................

Part 2 (In the case of the patient being a child, a responsible adult should certify where appropriate that the child understands the nature of the application).

I (name).............................................................................................................

of (address)..........................................................................................................................................

certify that the applicant understands the nature of this application.

Signed................................................................... Date.........................................

**IN ORDER THAT WE CAN SAFEGUARD YOUR INFORMATION COULD YOU PLEASE PROVIDE PROOF OF IDENTITY SUCH AS A COPY OF YOUR PASSPORT, DRIVING LICENCE, OR 2 UTILITY BILLS IN THE NAME OF THE APPLICANT DATED WITHIN THE LAST 3 MONTHS**

**PLEASE RETURN THE COMPLETED FORM TO:**

Patient Data Access Officer

Department of Imaging

Hammersmith Hospital

Du Cane Road

London

W12 0HS

**Email:** imperial.imagingcdrequest@nhs.net

**Telephone:** 020 3313 4907