Please send the completed application to:
Medical Records Department
Cromwell Hospital
Cromwell Road
London SW5 0TU

If you have any queries please
contact the Department via:
Tel: **+44 (0)20 7460 5528**
fax: **+44(0)20 7460 5513**
email: **medrec@cromwellhospital.com**

Hospital Contact Information

Cromwell Hospital
Cromwell Road
London SW5 0TU

Telephone: +44 (0)20 7460 2000
Facsimile: +44 (0)20 7835 2444

Email: info@cromwellhospital.com
Website: www.cromwellhospital.com

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CROMWELL
HOSPITAL

How to Access Medical Records

Committed to Excellence

The Access to Health Records Act 1990 and the Data Protection Act 1998 are the main statutory provisions that govern the release of medical records.

You can request to view your medical records and/or request a copy of your records. The request has to be in writing.

Please complete an Access to Medical Records Application Form, either inserted or which can be obtained from the Outpatients Reception Desk or via the Hospital website: www.cromwellhospital.com. Please ensure that when submitting the form you have signed the Declaration and you have enclosed the appropriate proof of identity as detailed below:

If you are requesting a copy of your own medical records:

- A copy of your Drivers Licence or Passport

OR

If you are requesting a copy of the medical records of:

Another Adult Patient:

- Proof of your identity as above
- A letter of authorisation from the patient

A Child:

- Proof of your identity as above
- A copy of the child's birth certificate; and
- In cases where the child is capable of giving consent themselves, a letter from the child authorising the application

A Deceased Patient:

- Proof of your identity as above
- A copy of the Death Certificate
- A copy of the Grant of Probate, if available, naming you as their representative or executor

In absence of the Grant of Probate or if you are not the representative or executor of the deceased, but still wish to access the records, please provide a letter explaining your reasons for the application and a copy of the death certificate.

Please note that:

- Your application will be processed no later than 40 days from the date of receipt. If this is not possible you will be advised of any delay
- If you have requested copies of your medical records, a charge of between £10 and £50 will be made to cover the costs of copying and sending the records to you. The amount charged will depend on the size of your medical records
- On receipt of your application the medical records will be accessed, and a copy of your application and the records sent to the Consultant, for permission to copy the records to you
- Once permission is obtained from your Consultant(s), you will be advised of the charge. The records will be copied and sent to you on receipt of payment
- If you have requested to view the records with a Consultant, you will be sent an appointment by the Consultant's secretary. The Consultant may charge you for this appointment
- If you have requested to view the records, and do not require a Consultant to be present, you will be sent an appointment to view the records by the Medical Records Manager
- You can request copies of your medical records after you have viewed them. (Please refer to previous point regarding charges)

ACCESS TO MEDICAL RECORDS APPLICATION FORM

CROMWELL
HOSPITAL

(Access to Health Records Act 1990/Data Protection Act 1998)

PLEASE COMPLETE THIS FORM IN **BLOCK LETTERS**

DETAILS OF THE PERSON WHOSE MEDICAL RECORDS ARE REQUESTED (please **PRINT**)

Surname ____________________

Forename(s) ____________________

Surname if different at time of attendance ____________________

Date of birth ____________________ Hospital Number (if known) ____________________

Address at time of attendance ____________________

____

____________________ Postcode ____________________

Telephone Number ____________________

Signature ____________________ Date ____________________

DETAILS OF APPLICANT, IF OTHER THAN THE PATIENT (please **PRINT**)

Surname ____________________

Forename(s) ____________________ Date of birth ____________________

Address ____________________

____

____________________ Postcode ____________________

Telephone Number ____________________ Relationship to patient ____________________

Signature ____________________ Date ____________________

SECTION OF RECORD TO BE COPIES/VIEWED (please circle appropriate response)

DO YOU REQUIRE A COPY OF ALL YOUR MEDICAL RECORDS? YES / NO

IF NO, STATE WHICH PART:

DO YOU REQUIRE THE COPIES TO BE SENT TO YOU? YES / NO

DO YOU WISH TO VIEW THE RECORDS AT THE HOSPITAL? YES / NO

DO YOU WISH TO VIEW THE RECORDS WITH A DOCTOR? YES / NO

PLEASE STATE REASON FOR APPLICATION (optional) ____________________

____

____

NOTE: Please supply the following documents when you submit this form:

IF YOU ARE REQUESTING COPIES OF YOUR OWN MEDICAL RECORDS

☐ A copy of your Drivers Licence or Passport

IF YOU ARE REQUESTING A COPY OF ANOTHER PERSON'S MEDICAL RECORDS

1. Another Adult Patient:

☐ Proof of your identity as above
☐ A letter of authorisation from the patient

2. A Child:

☐ Proof of your identity as above
☐ A copy of the child's birth certificate; and
☐ In cases where the child is capable of giving consent themselves, a letter from the child authorising the application

3. A Deceased Patient:

☐ Proof of your identity as above;
☐ A copy of the death certificate
☐ A copy of the Grant of Probate, if available, naming you as their representative or executor.

In absence of the Grant or Probate, or if you are not the representative or executor of the deceased, but still wish to access the records, please provide a letter explaining your reasons for the application and a copy of the death certificate.

DECLARATION

I declare that the information given by me is correct to the best of my knowledge and that (please tick as appropriate):

☐ I am the patient
☐ I have been asked to act by the patient and attach the patient's written authorisation
☐ I am acting in loco parentis and confirm either that the child is incapable of giving consent to the release of their records or that the child is capable of giving consent to the release of their records and enclose the child's written authorisation
☐ I am the deceased patient's Next of Kin / Executor
☐ I have read the information leaflet 'How to Access Medical Records' and am aware of the charges for copying the Medical Records
☐ I understand that the Hospital is not liable if I misplace or lose the copied records
☐ I have provided the following information as requested:

PLEASE TICK ALL RELEVANT BOXES

☐ Copy of Driving Licence ☐ Copy of Passport ☐ Copy of Child's Birth Certificate
☐ Letter of Authorisation from patient ☐ Copy of Grant of Probate

Please return the completed form to the:
Medical Records Department, Cromwell Hospital, Cromwell Road, London, England SW5 0TU

SECTION TO BE COMPLETED BY DOCTOR and MEDICAL RECORDS STAFF

Name of Consultant/Doctor authorising access (please PRINT): ______________________

Signature: ______________________ Date: ______________________

Medical Records staff confirming relevant document received (please Print): ______________________

Signature: ______________________ Date: ______________________

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