Information for patients

Accessing Health Records

This leaflet has been produced to accompany the ‘APPLICATION TO ACCESS HEALTH RECORDS’ form (DPA1) and to answer questions that you may have about your rights of access to information and how to apply.

The Trust endeavours to ensure that the information given here is accurate and impartial.

1. What constitutes a health record?

Health records consist of information relating to the physical or mental health condition of a patient created by a health care professional in connection with patient care. Health records usually consist of computer held information and include paper records which have been scanned, documents may include letters, charts, correspondence, out-patient and in-patient clinical notes etc. Some of our older records may still be held in their original paper format or on microfilm.

A one patient one record strategy exists between Circle NHS Nottingham Treatment Centre (NTC) and Nottingham University Hospitals (NUH). Subject Access Requests for records created by the NTC but maintained within NUH systems are processed by NUH on behalf of the NTC.

2. Complete an application form

Subject Access Requests must be made in writing, preferably using the “Application to Access Health Records” form DPA1 which can be downloaded from our internet site: [www.nuh.nhs.uk](http://www.nuh.nhs.uk)

Alternatively you can write to or telephone the Data Protection Administration Service on 0115 9249924 ext 62264 / 65222 / 64227 and a form will be sent to you.

Because health records are often complex and may involve large amounts of data, we will ask you to specify within your request what documents or data you wish to be supplied with.

Completed forms should be sent to:

Data Protection Administration Service  
Nottingham University Hospitals NHS Trust  
Queen’s Medical Centre Campus  
Derby Road  
Nottingham  
NG7 2UH
3. Who can access health records?

3.1 The Data Protection Act (DPA) and General Data Protection Regulation (GDPR) (applicable to living patients only)

This legislation permits the following to apply for access:

- The patient.
- A person authorised in writing to make an application on behalf of the patient.
- A parent or guardian of a person under 16, if that person agrees or it is considered by the clinician to be in the patient’s best interests. See Section 11.
- A Court appointed representative (Lasting Power of Attorney) (LPA) of someone who is not able to manage their own affairs. An attorney appointed on a health and welfare LPA can only makes decisions when the patient lacks capacity and the LPA document has been registered with the Office of the Public Guardian. See Sections 2 & 10.
- For any personal application not falling within one of these categories, the Trust will require a Court Order. The Trust will consider every application for such an Order on its own merits, having regard to the individual circumstances of each case, the best interests of the patients and the duty of confidentiality owed to that patient.

Within the Data Protection Act this is known as a Subject Access Request, the request must be made in writing and we must be able to verify the identity of the applicant.

3.2 The Access to Health Records Act 1990 (AHRA) (applicable to deceased patients only)

The Access to Health Records Act 1990 is the specific legislation that applies to records of deceased patients. Deceased patient’s personal representative(s) or a person who may have a claim arising from the patient’s death may apply for access to records under the provisions of the Access to Health Records Act 1990.

A Court appointed ‘personal representative’ of the deceased, executors and legal administrators of the deceased person’s estate have a right of access to relevant health records under the Access to Health Records Act. If you are applying for records in this capacity, we require all applicants to provide appropriate documentary evidence of their appointment, such as Grant of Representation from the Probate Service, a Letter of Administration or a copy of the Will where the applicant is named as the Executor.

‘Anyone else’ who applies for disclosure of records for deceased patients under the Access to Health Records Act must provide adequate evidence that ‘they have a claim arising from a patient’s death’ and therefore that they have a legal right of access under the Act. Applicants in this capacity are required to provide supporting documentary evidence to satisfy the Trust that they have such a claim arising. A copy of a claim instruction from a Solicitor, or evidence of a legal challenge of mental capacity or similar document will usually be sufficient. Requests must be made in writing.

4. How long will it take?

Because of the large numbers of applications we receive, we process ALL applications in strict date of receipt order. We are unable to provide an immediate response to applications or to fast track applications owing to the statutory procedures that we are required to follow.
For living patients, in accordance with the DPA/GDPR we will always try to provide copies of the records requested at the latest within 1 month/30 calendar days if it is at all possible to do so, this is calculated from receipt of a satisfactorily completed application.

If your request is complex or the records/data involved very large in quantity we may write to you in the first 30 days preceding your request and apply a time extension to your case. If we do this we will explain why this is necessary.

For deceased patients, in accordance with the AHRA, we will always try to provide copies of the records requested within 21 days where the record has been added to in the proceeding 40 days and within 40 days if it has not been added to. We will advise you if there is any delay in meeting this timescale and explain why.

5. How much do copies cost?

There is normally not a fee payable. However, we may apply a charge in some circumstances for instance, if we consider your request to manifestly unfounded or excessive, particularly if it is repetitive, or if it is in relation to additional copies of information already provided.

If we advise you that a fee is payable, the cost will be calculated on the overall administrative cost to us of providing the information.

6. How will I receive the records?

Computer held records

Many of our records are now computerised and supplied in their original digital format on a password protected CD-R. A large amount of paper records have also been scanned and held on computer. You will receive the password to CD-R in a separate letter to you in order to ensure your records are secure in transit.

Paper records

These are supplied as paper photocopies.

Delivery

Records will be forwarded to you using the Royal Mail’s ‘Special Delivery’ service. As this service requires a signature upon receipt, if there is no one available at home when the Post Office attempts the delivery, a card will be left advising you to collect the package from your local Post Office.

7. Do I have to give a reason why I want them?

No. You do not have to explain why you want to access records unless it is with a view to commencing legal proceedings (Clinical Negligence Pre-Action Protocol). However, as a large organisation it sometimes does help us to locate the exact information you require.

8. Do I have to prove who I am?

Yes you do. The Trust must be satisfied that an applicant is the patient or their authorised representative. This means we will ask for proof of identity and reserve the right to make further checks if necessary or refuse access if there is any doubt.
Applicants applying for a child’s health records will be asked to supply a copy of the child’s birth certificate and sign a form of authority confirming that they hold legal parental responsibility or if the applicant is not a parent, documentary evidence confirming parental responsibility.

9. **Children and young people**

All individuals, including children, have the right of access to their personal information. They also have a right to confidentiality. A child will not always be able to make his or her own request, therefore when we receive an application from, or on behalf of a child, it is our obligation to judge whether the child understands the nature of the request. This is known as Fraser (or Gillick) competent. The hospital is obliged to take a child’s view into consideration if he/she is Fraser competent as follows:

- Children aged 16 – 17 are regarded as adults and entitled to access their own personal information. Applications made on their behalf must be accompanied by their written consent.

- If the child aged under 16 does understand the nature of the request, he or she is entitled to exercise their own right of access, and in those circumstances we will reply to the child directly. Alternatively, a person with parental responsibility (as defined in the Children Act 1989 – see Appendix A) can make an application on behalf of the child and a reply will can be sent to them directly.

- If the child does not understand, the person with parental responsibility is entitled to make a request and to receive a reply.

In all cases, the person with parental responsibility is only permitted to make such a request in the best interests of the child, not in their own interests.

10. **Are there any exceptions?**

If healthcare professionals believe that information within records would cause serious harm to the physical or mental health of the patient or another person, they are entitled to refuse access to some or all records. Access may also be withheld or limited if the records relate to and identify another person other than a health professional.

If you are applying for the records of another party you will not be allowed to access any information which the patient gave on the understanding that it would remain confidential or was not to be disclosed to the applicant. If access to the record is refused, the healthcare professional is not required to tell you the reasons why.

If you are a parent or a person with parental responsibility for a child or young person who may not see their own record and the healthcare professional believes it is not in the best interests of the child for you to see the health record.

Some information within your records may also be withheld if it is about:

- Human fertilisation and embryology
- Adoption records and reports
- Information supplied by a Court
11. What if I only want to view my record?  
(Copies not required)

Patients may ask a clinician at the time of writing an entry into a record to view what has been written or recorded at that time. Requests to view retrospective entries will not be facilitated this way and can only be undertaken via provision of copies.

We normally satisfy our legal responsibilities to provide access to records by creating and supplying copies of records to applicants as very few records are now held solely on paper and we are unable to facilitate lengthy supervised one to one viewing of records on multiple electronic systems.

12. What can I do if I think some of the information in my records is incorrect?

If you believe that the information recorded about you is incorrect, you will need to let us know so that we are able to contact the person who entered the information. Corrections or removals of information are made in accordance with your legal rights within the Data Protection Act and the GDPR. We follow guidance issued by the National Information Governance Board for Health and Social Care (NIGB). We would normally correct factual mistakes and provide you with a copy of the corrected information. If you are not happy with an opinion or comment that has been recorded, we will add your own comments to the record so they can be viewed alongside any information you believe to be incorrect.

13. What if I can’t read the records or understand them?

If this is the case, we will contact the health care professional concerned and ask them to provide an explanation of any unfamiliar terminology used or a typed transcript of that part of your record, or possibly arrange for them to meet with you to discuss any difficulties you may have with understanding the information.

14. How long are records kept for?

Hospital records are kept in accordance with NHS guidance and for at least 8 years following the end of treatment or a person’s death. Records for some categories of care, for instance children’s records, are kept for much longer.

15. How can I make a complaint?

If you are not happy with the overall service you have received and you would like to know more about how to make a complaint, you may telephone the Patient Advice and Liaison Service (PALS) freephone: 0800 183 0204 / 0800 052 1195 or write to us at the following address:

The Chief Executive  
Nottingham University Hospitals NHS Trust  
Trust Headquarters  
City Hospital Campus  
Hucknall Road  
Nottingham  
NG5 1PB
The Information Commissioner's Office

If after exhausting our internal processes you believe that we have not complied with either the Data Protection Act or the Access to Health Records Act you may wish to seek advice from the Information Commissioner’s Office.

Post:  Information Commissioner's Office  
        Wycliffe House  
        Water Lane  
        Wilmslow  
        Cheshire  SK9  5AF

Fax:  01625 524 510
Tel:  01625 545 700
Email:  mail@ico.gsi.gov.uk

Feedback

We appreciate and encourage feedback. If you need advice or are concerned about any aspect of care or treatment please speak to a member of staff or contact the Patient Advice and Liaison Service (PALS):

Freephone:  0800 052 1195
From a mobile or abroad:  0115 924 9924 ext 65412 or 62301
E-mail:  pals@nuh.nhs.uk
Letter:  NUH NHS Trust, c/o PALS, Freepost NEA 14614, Nottingham NG7 1BR

www.nuh.nhs.uk

Please note:
Our offices are staffed for limited hours each day and are not within an area accessible to the public. If you wish to meet with a member of staff relating to your application you will need to telephone and book an appointment.

This document can be provided in different languages and formats. For more information please contact: Data Protection Administration Service, ICT Services, 0115 9249924 ext: 62264 / 65222 / 64227
The *Children Act 1989* sets out who has parental responsibility and these include:

- The child’s parents if married to each other at the time of conception or birth;

- The child’s mother, but not father if they were not so married *unless* the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;

- The child’s legally appointed guardian – appointed either by a court or by a parent with parental responsibility in the event of their own death;

- A person in whose favour a court has made a residence order concerning the child;

- A local authority designated in a care order in respect of the child (but not where the child is being looked after under section 20 of the *Children Act*, also known as being ‘accommodated’ or in ‘voluntary care’);

- A local authority or other authorised person who holds an emergency protection order in respect of the child.