LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

INFORMATION GOVERNANCE DEPARTMENT

CROWN STREET

LIVERPOOL L8 7SS

ACCESS TO PERSONAL DATA APPLICATION FORM (Subject Access Request)

This form should be used to request the release of information, which the Liverpool Women's Hospital holds about you. You cannot use this form to request information about somebody else unless you have their authorisation to do so. Requests received without such authorisation will not be processed

1. DETAILS OF THE INDIVIDUAL ABOUT WHOM THE INFORMATION IS REQUESTED (DATA SUBJECT)

Please provide the details of the individual about who the information is requested

Name . . . . . Date of Birth . . . . . .

Address . . . . . .

. . . . . .

Tel No . . . . . EMail Address . . . . . .

*Unique Identifier . . . . . .

Your Unit Number or NHS Number if you are/were a patient. Your National Insurance Number if you are/were a member of staff

2. HAS THE PERSON IN (1) BEEN KNOWN BY ADIFFERENT NAME OR HAD A PREVIOUS ADDRESS?

This will help identify any information held, where it is held in a different name from the name on file

Previous Name . . . . . .

Previous Address . . . . . .

3. WHAT INFORMATION ARE YOU REQUESTING?

Please describe what information is being requested. If you are requesting information in respect of a particular episode of care, please provide the approximate start date and end date of the episode of care. Please note that the Trust can only respond to the release of factual information, which it holds on the person named in (1) above and cannot interpret requests or provide advice on the information contained within the records.

4. WHO IS MAKING THIS REQUEST?

Please state whether you are the person stated in (1) above, or are acting on behalf of the person stated in (1) above (select as appropriate)

a) I am the person named in (1) above (the Data Subject) ☐

b) I am acting on behalf of the person named in (1) above ☐

If you are acting on behalf of someone and are requesting their information, please supply your details

Firstname . . . . . .

Surname . . . . . .

Address . . . . . .

. . . . . .

Signature of Applicant . . . . . .

Please Note: If you are representing someone then you will be required to demonstrate that you have authority

5. IMPORTANT INFORMATION THAT YOU SHOULD READY BEFORE SIGNING

I understand that if I request information about a person over whom I have parental responsibility then the Liverpool Women's Hospital will undertake an assessment of whether the person is able to understand the nature of the request, which may lead to my request being declined

I understand that I am not automatically entitled to view information on any person other than the person named in (1) above

I understand that it can take up to 1 month for me, or my authorised representative, to receive the requested information from the date of request

I understand that I will provide PHOTOGRAPHIC EVIDENCE to allow the Liverpool Women's Hospital to confirm my identity. I may be asked to collect the information personally if it considered there is a need to personally verify my identify

6. AUTHORISATION TO PROCEED TO BE COMPLETED ON BY THE PERSON IN (1) ABOVE

Please sign below to confirm that you would like the Liverpool Women's Hospital to proceeed with the request to provide your information

Signature of Data Subject (the Person named in (1) above)

. . . . . .

If you authorised an individual to act on your behalf, their details will be shown in (4) above. Please state the name of person who you have appointed to act on your behalf

Specify the Name of your Representative

. . . . . .

If you authorised an individual to act on your behalf, please sign below to authorise them to act on your behalf

Signature of Data Subject (the Person named in (1) above)

. . . . . .