## 

**Consent to Release Health Records under the Data Protection Act 2018/General Data Protection Regulations 2016 /Access to Health Records Act 1990**

This consent form must be signed by:

* The health professional who is currently, or was most recently, responsible for the clinical care of the data subject in connection with the information that is the subject of the request; or
* Where there is more than one such health professional, the health professional who is the most suitable to advise on the information that is the subject of the request.

Note: if the health professional has left the organisation the current or most suitable health professional must advise on the information that is the subject of the request.

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I *(name)*…………………………………………..………………... of *(dept.)* ……………………………………

confirm that I have viewed the health records of the data subject whose details are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Current/ Last Known Address** | **NHS Number** | **Date of Birth** |
|  | | | |
| **Other Names or Aliases** *(if applicable)* | **Previous Addresses** *(if applicable)* | | **Date of Death**  *(if applicable)* |

And *(tick box)*:

|  |
| --- |
| I authorise the release of the requested information to the applicant **(if consent covers more than one RDASH service’s records/notes, please identify the other RDASH services)**  ……………………………………………………………………………………………………………………  …………………………………………………………………………………………….……………………… |
| I authorise limited release of the requested information to the applicant because *(give details)* |
| ………………………………………………………………………………………………………………… |
| ………………………………………………………………………………………………………………… |
| I do not authorise the release of the requested information to the applicant because *(give details)* |
| …………………………………………………………………………………………………………………  …………….......................................................................................................................................... |

*(Please note that a reason for not releasing requested information is required for Information Governance purposes and will not be disclosed to the applicant)*

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# **Declaration**

By signing this form I am agreeing that:

* A copy of the information, for which I have authorised the release, is attached and the original information has been returned to the place of storage
* The attached copy information pertains to the correct data subject, the details of whom are shown above
* Third party information, for which we do not have consent to release, has been removed from the attached copy information
* Information that is likely to cause serious harm to the physical or mental health of the data subject or another person has been removed from the attached copy information

Signed: ………………………

Date: …………………………