

APPLICATION ON BEHALF OF A PATIENT FOR HOSPITAL MEDICAL RECORDS FOR USE WHEN COURT PROCEEDINGS ARE CONTEMPLATED

This should be completed as fully as possible

Insert
Hospital
Name
and
Address

TO: Medical Records Officer

Hospital

1	Full name of patient (including previous surnames)	
(a)		
(b)	Address now	
(c)	Address at start of treatment	
(d)	Date of birth (and death, if applicable)	
(e)	Hospital ref. no if available	
(f)	N.I. number, if available	
2	This application is made because the patient is considering	
(a)	a claim against your hospital as detailed in para 7 overleaf	YES/NO
(b)	pursuing an action against someone else	YES/NO

3	Department(s) where treatment was received	
4	Name(s) of consultant(s) at your hospital in charge of the treatment	
5	Whether treatment at your hospital was private or NHS, wholly or in part	
6	A description of the treatment received, with approximate dates	
7	If the answer to Q2(a) is 'Yes' details of	
	(a) the likely nature of the claim	
	(b) grounds for the claim	
	(c) approximate dates of the events involved	
8	If the answer to Q2(b) is 'Yes' insert	
	(a) the names of the proposed defendants	
	(b) whether legal proceedings yet begun	YES/NO
	(c) if appropriate, details of the claim and action number	

9	We confirm we will pay reasonable copying charges	
10	We request prior details of (a) photocopying and administration charges for medical records	YES/NO
	(b) number of and cost of copying x-ray and scan films	YES/NO
11	Any other relevant information, particular requirements, or any particular documents <u>not</u> required (e.g. copies of computerised records)	
	Signature of Solicitor	
	Name	
	Address	
	Ref.	
	Telephone Number	
	Fax number	
<p style="text-align: right;"><i>Please print name beneath each signature. Signature by child over 12 but under 18 years also requires signature by parent</i></p> <p>Signature of patient</p> <p>Signature of parent or next friend if appropriate</p> <p>Signature of personal representative where patient has died</p>		

FIRST RESPONSE TO APPLICATION FOR HOSPITAL RECORDS

NAME OF PATIENT		
Our ref		
Your ref		
1	Date of receipt of patient's application	
2	We intend that copy medical records will be dispatched within 6 weeks of that date	YES/NO
3	We require pre-payment of photocopying charges	YES/NO
4	If estimate of photocopying charges requested or pre-payment required the amount will be	£ / notified to you
5	The cost of x-ray and scan films will be	£ / notified to you
6	If there is any problem, we shall write to you within those 6 weeks	YES/NO
7	Any other information	
	Please address further correspondence to	
	Signed	
	Direct telephone number	
	Direct fax number	
	Dated	

SECOND RESPONSE ENCLOSING PATIENT'S HOSPITAL MEDICAL RECORDS

Address

Our Ref.

Your Ref.

1	NAME OF PATIENT: We confirm that the enclosed copy medical records are all those within the control of the hospital, relevant to the application which you have made to the best of our knowledge and belief, subject to paras 2–5 below	YES/NO
2	Details of any other documents which have not yet been located	
3	Date by when it is expected that these will be supplied	
4	Details of any records which we are not producing	
5	The reasons for not doing so	
6	An invoice for copying and administration charges is attached	YES/NO
	Signed	
	Date	