

or has been given authority to deal with the affairs if there is no will, or

- he or she is considering making a claim for compensation arising from the death

Only information relevant to any potential claim arising from the death will be made available.

Independent Mental Capacity Advocate (IMCA)

Adults who have been assessed under the Mental Health Act as being unable to make major decisions about their care or treatment, and who do not have a suitable relative or friend, will be given a trained independent IMCA to make sure decisions are taken in their best interest.

An IMCA may have access to the patient's health records if they are helpful to the decision being made.

Power of Attorney

If a patient is unable to make decisions because they are so unwell, they may give a friend or relative permission to act on their behalf. This is called giving them Power of Attorney (PA).

Depending on the level of PA given, that person may make decisions about the patient's care or treatment, and have access to his or her health records. They must protect the confidentiality of any information in the health records.

Patient Advice and Liaison Service (PALS)

If you have concerns about any aspect of the service you have received in hospital and feel unable to talk to those people responsible for your care, call PALS on:

- Royal Brompton Hospital **020 7349 7715**
- Harefield Hospital **01895 826 572**

You can also email pals@rbht.nhs.uk. This is a confidential service.

Information

If you would like more advice about any aspect of this leaflet, please contact:

Information Governance

Tel: **020 7352 8121** ext. **4473**

Caldicott Guardian

Email: caldicottguardian@rbht.nhs.uk

Clinical Records

Royal Brompton Hospital:

Email: clinicalrecordsrbh@rbht.nhs.uk

Tel: **020 7352 8121**

Harefield Hospital:

Email: clinicalrecordshh@rbht.nhs.uk

Tel: **01895 823 737**



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textphone: (18001) 01895 823 737

website: www.rbht.nhs.uk

إذا كنت ترغب في الحصول على ترجمة فورية لمضمون هذه الوثيقة إلى اللغة العربية، يرجى منك الاتصال بأحد مستخدمينا بجناح المصلحة التي يتم فيها استشفائك. أحد موظفينا سيسعى لترتيب إجراءات الترجمة وإتمامها في الوقت المناسب لك.

Brosurteki bilginin Türkçe tercemesi için tedavi görüyor olduğunuz bölüme basurunuz. Bölüm personeli tercemenin gerçekleşmesini en kısa zamanda ayaracaktır.

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Your health records



Introduction

Your health records are either written in a file or typed on a computer and stored electronically. They contain comprehensive information about all aspects of your health.

Doctors, nurses and healthcare professionals write in them, and they can include:

- clinical notes
- letters to and from healthcare staff
- laboratory reports
- imaging scans e.g. X-rays
- printouts from monitoring equipment
- clinical photographs
- recordings of telephone conversations
- digital recordings from a consultation or treatment

Keeping your health records safe

Any member of staff who records, handles, stores or comes into contact with any information about you has a duty to keep it safe and secure.

Who can access my health records?

The staff involved in your care and treatment will see your health records.

Information from your health records may also be shared with community staff

or services where you receive care and treatment, e.g. GPs, community nurses or social services.

Data Protection Act 1998

Your health records contain important and sensitive information that can be used to identify you e.g. name, date of birth, address.

Under the Data Protection Act 1998, all health records that contain identifiable information must be kept in a safe and secure place and only looked at by authorised staff.

The Act clearly states that you have the right to:

- see your own health records
- ensure that information is factually correct
- request an investigation if you believe that your health records have not been handled in the way the Data Protection Act 1998 describes

For more information on the Act, speak to the clinical records manager (details overleaf).

How can I access my health records?

A copy of your health records can be sent to you from the clinical records department. To request them you will need to complete a form and show photographic proof of identity e.g. a passport or driving licence.

Once staff in the clinical records department receive your request they have 40 calendar days to respond.

Is there a charge?

An administrative fee may be charged to cover the time spent providing your health records.

- Health records updated in the last 40 days – **free of charge**
- Health records held electronically – these will cost **up to £10**
- Copies of older paper records and results, e.g. radiology images (X-rays) – these will cost **up to £50**

If you have questions about how much your request will cost, please contact the clinical records department.

Information provided by other people

Unless written permission has been given by a person or the circumstances are considered reasonable, you will not be able to see another person's health records e.g. a family member who has been mentioned in your own health records.

The same applies to information that has been given by someone else about you, other than healthcare professions e.g. nurses, doctors or pharmacists.

Healthcare professionals do not need to seek permission from a colleague to show you information recorded by

them e.g. a GP cannot withhold a letter from a hospital consultant on the grounds that he or she needs the consultant's permission first.

Children

Parents of children under 12 can see their child's health records, unless it is deemed unsafe for the child for them to do so.

For children over 12, parents will need to ask their child's permission to see their health records.

Parents must show relevant documents to prove they have legal responsibility for that child before information is shown to them.

Information that a child has told to a member of staff in confidence will not be shared with the parents.

Relatives of someone who has died

All health records are confidential, even after someone has died. Relatives are not automatically allowed to see health records of a deceased relative.

Under the Access to Health Records Act 1990 a relative can only apply to see a deceased patient's health records if:

- he or she is acting as the deceased person's representative e.g. has been appointed as the executor of their will,