CHIE
Care and Health Information Exchange

NHS
South, Central and West
Commissioning Support Unit

REQUEST TO VIEW YOUR HEALTH RECORD AUDIT TRAIL

Please complete and return this form, along with the appropriate identification to:

Applications Support
Care and Health Information Exchange
Building 003 Fort Southwick
James Callaghan Drive
Fareham
Hampshire
PO17 6AR

1. Please provide the following details and complete as necessary:

Please Tick: **Dr** ☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐

First Name(s): (in full) .....

(Amend details if applicable) .....

Last Name: .....

(Amend details if applicable) .....

Home Address: .....

(Amend details if applicable) .....

.....

.....

.....

Date of Birth: .....

(Amend details if applicable) .....

Doctor's Name (if known): .....

(Amend details if applicable) .....

Surgery Name & Address: .....

(Amend details if applicable) .....

2. In order to ensure that the audit is being carried out for the correct person, proof of identification is required. Please enclose a **PHOTOCOPY** of **TWO** or **MORE** of the following showing your:

   First name
   Last name
   Address
   Date of birth.

Examples are:

<table>
<tr><td rowspan="4">Current UK Driving Licence</td><td rowspan="4">or</td><td>Personal ID</td><td rowspan="4">plus one of the following</td><td>Address ID</td></tr>
<tr><td>Current signed passport</td><td>Recent utility bill (Within the last 3 Months)</td></tr>
<tr><td>ID Card</td><td>Local Authority Council Tax Bill</td></tr>
<tr><td>Birth Certificate</td><td>Bank/Building Society Statement of personal account</td></tr>
</table>

If this information is not provided we cannot process this application any further.

3. **Declaration: To be completed by the applicant. Please note that any attempt to mislead may result in prosecution.**

   I ……..certify that the information given on this application form is true. I understand that it is necessary for the Care and Health Information Exchange to confirm my identity, and that it may be necessary to make further checks in order to ensure the correct information is provided.

4. Please sign below to confirm that you give permission for the Care and Health Information Exchange Co-ordinator to access and print out your Care and Health Information Exchange Audit Trail, in order to provide you with a copy.

…… ……

Signature Date