# Policy: C19
## Copying Letters to Patients

<table>
<thead>
<tr>
<th>Version:</th>
<th>C19/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified by:</td>
<td>Policy Review Group</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>15th April 2015</td>
</tr>
<tr>
<td>Title of Author:</td>
<td>Mental Health Act Office / Health Records Manager</td>
</tr>
<tr>
<td>Title of responsible Director</td>
<td>Director of Nursing and Patient Experience</td>
</tr>
<tr>
<td>Governance Committee</td>
<td>Trust Information and Governance Group</td>
</tr>
<tr>
<td>Date issued:</td>
<td>21st April 2015</td>
</tr>
<tr>
<td>Review date:</td>
<td>April 2018</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All staff Trust wide</td>
</tr>
<tr>
<td>Disclosure Status</td>
<td>B Can be disclosed to patients and the public</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EIA / Sustainability</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Other Related Procedure or Documents:**
## C19 - Copying Letters to Patients

### Version Control Sheet

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Title of Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C19/01</td>
<td>April 2005</td>
<td>Director of Nursing</td>
<td>New Policy issued</td>
<td></td>
</tr>
<tr>
<td>C19/02</td>
<td>April 2008</td>
<td>Director of Nursing</td>
<td>Policy revision</td>
<td></td>
</tr>
<tr>
<td>C19/03</td>
<td>April 2009</td>
<td>Executive Director of High Secure Services &amp; Nursing</td>
<td>Policy revised</td>
<td>Revised in light of MHA 2007 &amp; MCA 2005.</td>
</tr>
<tr>
<td>C19/04</td>
<td>8th May 2009</td>
<td>Executive Director of High Secure Services &amp; Nursing</td>
<td>Revised Policy issued</td>
<td></td>
</tr>
</tbody>
</table>
# C19 - Copying Letters to Patients

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Flowchart</td>
<td>3</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>3. Scope</td>
<td>4</td>
</tr>
<tr>
<td>4. Definition</td>
<td>4</td>
</tr>
<tr>
<td>5. Duties</td>
<td>5</td>
</tr>
<tr>
<td>6. Systems and recording</td>
<td>6</td>
</tr>
<tr>
<td>7. The principles of copying letters to patients</td>
<td>6</td>
</tr>
<tr>
<td>8. Circumstances when copying letters is not appropriate</td>
<td>7</td>
</tr>
<tr>
<td>9. Consent to receipt of letters: identifying appropriate recipients</td>
<td>8</td>
</tr>
<tr>
<td>10. How is it to be done?</td>
<td>9</td>
</tr>
<tr>
<td>11. Training</td>
<td>12</td>
</tr>
<tr>
<td>12. Monitoring compliance with the policy</td>
<td>13</td>
</tr>
<tr>
<td>13. Fraud statement</td>
<td>13</td>
</tr>
<tr>
<td>14. References</td>
<td>13</td>
</tr>
<tr>
<td>15. Supporting documents (trust documents)</td>
<td>13</td>
</tr>
<tr>
<td>16. Glossary of terms / acronyms</td>
<td>14</td>
</tr>
<tr>
<td>17. Appendices</td>
<td>14</td>
</tr>
<tr>
<td>APPENDIX 1</td>
<td>15</td>
</tr>
</tbody>
</table>
1. Flowchart

1.1 The NHS Plan 2000 made a commitment that patients should be able to receive copies of clinicians’ letters about them as of right. A working group convened by the Department of Health (DH) in 2001 set out the background to the initiative in a report in February 2002. The DH subsequently issued Good Practice Guidelines in April 2003. The principal aim of the DH policy was (and is) to improve communications between healthcare professionals and patients and to increase patients’ involvement in their care and treatment.

1.2 The provision of information to patients to support their decision making in their care is a standard set by the NHS Litigation Authority (Risk Management...
Standards 2013/2014, standard 6.2). Trusts are no longer assessed against these standards but they remain available to use to promote best practice.

1.3 This policy summarises the DH best practice guidelines for implementation within the Trust. Clinical letters written by therapists to other clinicians either within West London Mental Health Trust or to others outside the Trust should be copied to the patient to whom they refer.

1.4 The clinician in charge of the care of the patient must make a record in the patient’s notes that they have asked the patient whether they wish to have a copy of clinical correspondence and the patient’s reply. This can be recorded in RiO (within the progress notes) or the patient can be asked to complete a form such as the sample form in Appendix 1. If a form is used, it must be saved to or placed in the patient’s clinical record. This decision must be kept under review and the clinician must update the patient’s record to note the discussion regarding the copying of letters. Each Clinical Service Unit may set a standard for the review of the decision with the patient. This policy recommends that this is done as part of the Care Programme Approach (CPA) review or if the patient is not under CPA, then at least annually.

1.5 The clinician writing the letter is responsible for ensuring a copy is made available to the patient. All recipients of the letter should be listed on the letter. The Trust’s copy of the letter will be saved in the patient’s health record (usually electronically) in accordance with the Trust policy on Health Records (H8).

3. **Scope**

3.1 The policy is applicable to all current patients / service users in the Trust.

3.2 This policy applies to staff records in the Occupational Health Department.

4. **Definition**

4.1 **What constitutes a letter?**

A ‘letter’ includes communications between different health professionals, for instance those from and to GPs, hospital doctors, nurses, therapists and other healthcare professionals. (This practice applies to Health and Social Care staff who work within Trust Multi-Disciplinary Teams). Different types of letters include, among others:

- Letters or forms of referral (including hand-written two-week wait referral forms) from primary care health professionals to other NHS services
- Letters from NHS health professionals to other agencies (such as social services or housing, employers or insurance companies)
- Letters to primary care providers from hospital consultants or other healthcare professionals following discharge or following an outpatient consultation or episode of treatment
• Letters generated where the Trust provides in-reach services to other organisations will be subject to the host organisation’s policy
• Letters from the Occupational Health Department of the Trust to the Human Resources department.

4.2 The DH guidance relates particularly to letters, but the principles of sharing information can also be applied to any documentation that refers to the patient. Care plans and discharge summaries are documents that should be copied to patient, provided the exemptions outlined below do not apply.

4.3 This guidance does not relate to the copying of ‘raw data’ such as test results or reports. Such data could include, for instance, an x-ray and its accompanying report, or the results of blood tests taken as part of a wider investigation of symptoms. In due course, the outcome of such tests should be included in a letter that is copied to the patient. Where no such letter is needed (for instance where a general practitioner has commissioned a range of tests), some other means of communicating the results to patients will be necessary.

4.4 Since the Department of Health issued guidelines in 2004 the method of communicating have changed considerably and correspondence is now frequently sent by secure e-mail. Most letters will be sent electronically, as an attachment to an e-mail. This is still a letter and a copy should be provided to the patient.

4.5 Sometimes clinical information will be conveyed to another clinician in the form of an e-mail (rather than a separate attachment). If this information is intended to be kept on the patient file, then it should be treated in the same way as a letter and a copy should be provided to the patient. If it is simply a message, not intended to form a permanent part of the patient record, then a copy is not appropriate. An example might be an e-mail from a Consultant in the Trust to doctor in another Trust asking if he has a date yet to come to the hospital to provide an independent assessment of the patient (there would have been a formal written request prior to this check). A response with a date might then be received. In most cases, this would not be saved to the file and quickly deleted from the Trust e-mail system. This would not be regarded as a letter within this policy.

5. Duties

5.1 Chief Executive
The Chief Executive is responsible for ensuring that the Trust has policies in place and complies with its legal and regulatory obligations.

5.2 Accountable Director
The accountable director, in this case the Director of Nursing & Patient Experience, is responsible for the development of relevant policies and to ensure they comply with relevant standards and criteria where applicable. The accountable director is also responsible for trust wide implementation and compliance with the policy.

5.3 Managers
Managers are responsible for ensuring policies are communicated to their teams / staff. They are responsible for ensuring staff attend relevant training and adhere to the policy detail. They are also responsible for ensuring policies applicable to their services are implemented.

5.4 **Policy Author**
The policy author is responsible for the development or review of a policy as well as ensuring the implementation and monitoring is communicated effectively throughout the Trust via CSU / Directorate leads and that monitoring arrangements are robust.

5.5 **Local Policy Leads**
Local policy leads are responsible for ensuring policies are communicated and implemented within their CSU / Directorate as well as co-ordinating and systematically filing monitoring reports. Areas of poor performance should be raised at the CSU / Directorate SMT meetings.

5.6 **Specific Staff for Policy**
This policy is aimed primarily at clinical and administrative staff in the Trust.

5.7 **All Staff**
All staff must be aware of and adhere to this policy as it impacts on any clinical or advisory responsibility they may have.

6. **Systems and recording**

6.1 **Where recorded:** In almost all cases, the discussion with the patient and his/her response to having copies of letters will be recorded on RiO, the patient electronic clinical database. If this is not possible, clinicians should use the designate patient electronic or paper health record.

6.2 **Recorded by who:** Usually, the clinician in overall charge of the care of the patient will complete the RiO record. For detained patients, this will be the Responsible Clinician. However, other clinicians can make RiO entries when relevant.

6.3 **When recorded:** The patient should be asked about receiving copy letters as early as possible in their care and treatment episode (or pathway) within the Trust. Their reply should be kept under review by the clinician in charge of treatment (see 2.4).

7. **The principles of copying letters to patients**

7.1 **Improving communications**
As a general rule and where patients agree, letters written by one health professional to another about a patient should be copied to the patient or, where
appropriate, parent or legal guardian. This applies to all patients, voluntary or detained. The underlying principle is that all letters that help to improve a patient’s understanding of their health and the care they are receiving should be copied to them as of right. Where the patient is not legally responsible for their own care (for instance a young child, or a child in care), letters should be copied to the person with legal responsibility, for instance a parent or guardian. When letters are copied to persons other than the patient, the MHA Code of Practice provides guidance on confidentiality (Chapters 2 and 18).

7.2 **No Surprises:**
Where the letter contains abnormal results or significant information that has not been discussed with the patient, it will be important for arrangements to be made to give the patient a copy of the letter after its contents have been discussed in a consultation with the receiving professional. As a general rule the contents of copied letters should reflect the discussion in the consultation between the patient and the healthcare professional, and there should be no new information in the letter that might surprise or distress the patient.

7.3 **Writing directly to patients**
In many cases, healthcare professionals (or services, such as screening services) write directly to patients or parents of patients, copying the letter to the GP or others as necessary. The DH guidelines endorsed this practice.

8. **Circumstances when copying letters is not appropriate**

8.1 There may be reasons why the general rule of copying letters to patients should not be followed. These include:

- where the patient does not want a copy. A reason does not have to be given

- where permitting access to the information contained in the letter would be likely to cause serious harm to the physical or mental health condition of the person to whom the letter relates or any other person (including a health professional)

- where the information in the letter relates to a third person unless that person has consented to the disclosure or could be fully anonymised. Another health professional is not deemed to be a third party. (Refer to Trust Data Protection policy D5 for more detail on this exemption)

- where special safeguards for confidentiality may be needed

- where there are specific security considerations particularly in high and medium secure settings

- where a case is particularly sensitive, for example, child protection, it may not be appropriate to copy the letter. A child protection matter may have been
reported or is under investigation. The best interests of the child must come first.

8.2 Giving of ‘bad news’ is not in itself enough to justify not copying a letter. When the DH introduced this initiative, pilot studies showed that it is sometimes the case that health professionals are anxious to protect patients, who themselves often wish to have as much information as possible, even if it may be ‘bad news’ or uncertainty.

8.3 However, as noted in the section above, a health professional may make a decision not to disclose a letter or report applying the ‘serious harm’ test. This will be a matter of clinical judgement. The provision to withhold information has a statutory basis in The Data Protection (Subject Access Modification) (Health) Order 2000. If a letter is withheld, the reason must be recorded in the clinical notes.

9. **Consent to receipt of letters: identifying appropriate recipients**

9.1 In line with the overall NHS policy of informed consent, it is for each patient to decide whether they wish to receive copies of letters written about them by health professionals. The copying letters policy is underpinned by a presumption of the patient’s informed consent to the receipt of any letter. The aim is that within a consultation, the possibility of receipt of the letter should be raised as part of the wider discussion about ‘what will happen next.’ In other words, patients should routinely be asked during a consultation whether they want a copy of any letter written as a result of that consultation and any related tests or interventions, and there should be a clear process for recording their views, similar to that for recording their consent to treatment.

If there is doubt about the patient's mental capacity to make a decision about receiving copies of letters, an assessment of their capacity can be undertaken by the treating clinician and recorded in the patient’s clinical records (refer to the Trust’s Mental Capacity Policy, M9).

9.2 A leaflet about this policy is included in Patient and Carer Information Packs. The ‘Copying letters to service users and patients’ leaflet can be obtained from the Communications Team. Trust staff should ensure copies are available to patients.

9.3 **Handling records**

The circumstances of letters about an individual patient will vary. It might be sufficient to seek consent once rather than each time a letter is written as long as it is explained at the start of treatment that copies of letters will be sent routinely to the patient or responsible person unless the patient decides to opt out of receiving copies of letters, which can be done at any time. Good practice suggests, however, that the patient be reminded each time a letter is to be copied.

9.3.1 Where a letter is to be written at the request of an outside agency, other factors apply in addition to the question of whether the letter should be copied to the patient. Organisations and practices must be sure that relevant legislation on data protection (and writing letters to insurance companies) is complied with.
9.3.2 There may be occasions when one healthcare professional wishes to comment on the clinical care provided by another and offer advice on the care of future patients with a particular condition or symptoms. It may not be appropriate for such information to be copied to the patient, but it is important for continuing professional development and clinical governance that such an opportunity for professional development is not lost. The professional concerned should write a separate letter that is not copied to the patient.

9.4 Carers
Some adults have carers, family members or others who are actively involved in their care. Frequently patients want information shared with their carers and/or family members. With the patient’s consent, copies of letters can be sent to the carer. Copies of letters to carers may be particularly important where medication is changed following discharge from hospital. Again, in the absence of a clear legal framework for deciding what to do, health professionals will often have to exercise judgement in deciding where it is in the patient’s best interests to share information with a carer. If the person is a young carer, any information must be appropriate to the age and understanding of the young person (helpful guidance is provided in the MHA Code of Practice, paragraph 2.43). Best interest decisions made by clinicians on behalf of patients who lack the capacity to make a decision on the involvement of a carer must be fully recorded in the patient RiO record.

9.4.1 Sometimes the patient will not want a letter copied or shown to the carer. Both the patient and the carer have the right to expect that information provided to the health service will not be shared with other people without their consent. In such circumstances, unless there is an over-riding reason to breach confidentiality, the wishes of the patient must be respected. The DH expects that carers of people with mental illness should be provided with as much information as possible to enable them to carry out their caring role as effectively as possible without breaking the patient’s confidentiality.

9.5 Children and young people
It is expected that young people aged 16 and 17 will be offered copies of letters. It is up to healthcare professionals to assess the competence of younger children to understand and make a decision (referred to as Gillick competence). It is good practice to offer adolescents consultations alone so that they have the opportunity to speak freely and give information that they may be unwilling to talk about in front of their parents. In such cases, young people may prefer to collect in person copies of letters giving personal information rather than having them sent to their home.

9.6 The issue may arise as to whether a letter should be copied to the young person or their parents. Some initiatives in copying letters have been developed in children’s services, and the general experience is that there are few difficulties, as long as the issue is discussed with the family. Often adolescents appreciate the letter being sent to them. Where parents are separated, it is important to discuss who should receive the copies of letters.

10. How is it to be done?
10.1 **Frequency of copies**
Where there is frequent communication, the person responsible for writing the letter should consider if it would be useful for the patient to have a copy every time. The decision should be based on a discussion with the patient about whether receiving a copy will improve communication with them and assist them to understand their own healthcare or treatment.

10.2 **Where there is no safe address to receive mail**
Patients who do not have a safe postal address should be able to collect letters.

10.3 **Secure storage of letters**
In-patients must be advised by members of the clinical team to keep their personal clinical information in a safe place in their rooms and not leave any letters in a general area on the ward. If requested to do so, staff should look after the letter for the patient in a safe and secure area on the ward or in a clinician’s locked cabinet.

10.4 **Writing style and standard letters**
Letters between healthcare professionals are ‘personal data’ forming part of the patient’s record therefore it is important that they:
- are adequate for their purpose and accurate
- are written clearly
- avoid unnecessarily complex language and subjective statements
- avoid extraneous information
- use plain English to improve readability
- avoid giving offence unintentionally or generating misunderstandings
- avoid (where possible) unnecessarily technical terminology and acronyms
- set out the facts and avoid unnecessary speculation
- confirm information given in discussion with the patient in the consultation in a language that the recipient can read and understand

10.4.1 A balance is required between simplification for the patient’s understanding and what is needed for the primary purpose of a letter between healthcare professionals discussing symptoms, test results and possible diagnoses or treatment. Clinical accuracy and ensuring the professional receiving the letter has all the information he/she needs is the main purpose of the letter. It is important not to compromise this in order to make the letter easier to understand.

10.4.2 Some healthcare professionals prefer to write letters directly to patients, with a copy to the GP or other healthcare professionals. Evidence shows that patients appreciate such practices, which give the clinician the option of adding additional information and advice about lifestyle and management of the illness or condition.

10.5 **How copies are provided**
Options for providing copies of letters include:
- a printed copy of the letter. Envelopes should be marked private and confidential and should not be stamped with a hospital/ Trust logo or address
- copies in large print, or in some other format, such as on audio-tape
- viewing letters on screen in the hospital or practice
- sending by post or collection from an appropriate place, where there are concerns about privacy at home
10.6 As improved information systems evolve, it should become easier to generate an extra copy of a letter for a patient. When patients are able to access their records through safe internet sites, paper copies of letters may not be required.

10.7 **People with special communication or language needs**

Patients should be able to receive copies of letters in a form they can understand and use. This is particularly important for statutory information relating to detention under the Mental Health Act and statutory rights. The patient leaflet ‘Copying letters to service users and patients’ can be requested in a range of languages. Clinicians can ask for advice about interpreter and translation services from the Patient Services Department at Ealing or the Security Department at Broadmoor.


10.7.2 Some people cannot read well enough to understand a copied letter. Such people are often reluctant to admit the problem, and it may fall to them to seek someone to help them read the letter.

10.7.3 Consideration should be given to the needs of people with learning disabilities or deaf people, who may not easily read written English. People with visual impairment can often read large print. They can also access their information on computer in the GP practice or hospital, using voice recognition or other specialist software.

10.8 **Further information for patients**

Some patients may want further information about the contents of the letter or an explanation of terms. The letter should indicate who can be contacted for further information. The patient can also refer to the local Patient Advice and Liaison Service (PALS) or NHS Direct on-line.

10.9 **Correcting inaccurate records**

Healthcare professionals who routinely share records with patients report that patients and carers often identify inaccuracies and mistakes. There should be arrangements to amend/annotate their records to ensure they are correct. Whilst this may initially be time-consuming, the result should be improved and more accurate records that comply with the provisions of the DPA 1998 and benefit the overall quality of the service. Procedures for making such changes are described in the Trust Data Protection Policy and refer to paper and electronic records. For completeness the relevant paragraphs are reproduced below:

“The DPA Act defines information as inaccurate either if it is inaccurate or misleading or if an opinion is based upon inaccurate information.

A data subject (the patient) has a right to have inaccuracies corrected and also to have opinions revised if based upon inaccurate information.

In every case where the accuracy of data is challenged by the data subject the matter must be fully and promptly investigated. A challenge to the accuracy of data
should normally be made in writing; however if the challenge is made by the data subject in person and their identity is not in doubt the challenge can be dealt with.

All reasonable steps should be taken to resolve the issue and the data subject must be informed of any corrections made. Where it is not possible to resolve the matter or the requested change is clearly incorrect the record should be annotated accordingly. It may be appropriate to agree with the data subject that their alternative account is filed alongside the original that they object to.

In all cases where a correction cannot be made or the data subject is dissatisfied with the outcome the Trust’s Information Governance Manager must be informed.

If a data subject is not satisfied with the outcome they should be referred in the first instance to the Trust’s complaints procedure. If the matter cannot be resolved they have the right to apply to a court for correction”.

10.10 Protecting confidentiality
In reviewing their security and confidentiality procedures, health professionals copying letters should assess and take steps to minimise the following risks:

- breaches of confidentiality of information of third parties
- breaches of confidentiality of the patient’s own information where communications are misdirected or read by someone other than the patient or his or her authorised agent.
- breaches of confidentiality of letters kept insecurely by an in-patient

10.11 Procedures must be in place to minimise the likelihood of information being accessed by unauthorised people and ensure patients who choose to have information posted are aware of the risks. Envelopes must be marked ‘confidential’ and patients’ addresses routinely checked. Patients’ full names, rather than initials, should be used as a matter of good practice. It is also good practice to check whether two people with the same name live at one address.

10.12 There must be clarity about who is responsible for checking and recording:

- the patient’s address and full name for addressing a letter
- the patient’s preference on method of communication and format

10.13 Sources of advice
Copying letters is part of wider initiatives to strengthen patient and public involvement in health. Patient Advice and Liaison Services (PALS) is a good source of advice on patient issues in implementing the policy and will provide support to patients who want further information.

11 Training

11.1 There is no specific training for this policy. The principles of information governance, data sharing and patient confidentiality are part of the Trust Information Governance training which is mandatory for all Trust staff.
12 Monitoring compliance with the policy

12.1 Each Clinical Service Unit will appoint a suitable person to monitor this policy against the main performance standards listed below. The nominated post holder and the timescales for auditing will be recorded within Senior Management Team minutes. A CSU may choose to incorporate other standards appropriate to the service under review:

- The patient has been given information about this policy and this is recorded in the health record.
- The patient has been asked to indicate if he/she wishes to receive copies of letters and their response has been recorded in the health record.
- With regard to correspondence, all letters indicate who has been copied in.
- Where professionals have made a judgement not to send a copy of a letter, the reasons are documented in the clinical notes.

13. Fraud statement

Not applicable

14. References

- The NHS Plan, Department of Health 2000
- Good Psychiatric Practice: Confidentiality and Information Sharing, Royal College of Psychiatrists 2006
- NHS Litigation Authority, Risk Management Standards, 2013/2014
- The Data Protection Act 1998
- Equality Act 2010
- Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health Act Code of Practice, 2008, Chapters 2 and 18

15. Supporting documents (trust documents)

- Trust Consent to Treatment Policy (C7)
- Trust Data Protection Policy (D5)
- Trust Mental Capacity Act Policy (M9)
• Trust Care Programme Approach Policy (C2)
• Trust Health Records Policy (H8)

16. Glossary of terms / acronyms

<table>
<thead>
<tr>
<th>DH</th>
<th>Department of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>DPA</td>
<td>Data Protection Act</td>
</tr>
<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Services</td>
</tr>
<tr>
<td>CSU</td>
<td>Clinical Service Unit</td>
</tr>
<tr>
<td>SMT</td>
<td>Senior Management Team</td>
</tr>
</tbody>
</table>

17. Appendices

Appendix 1 – Sample letter to a Patient
APPENDIX 1

Name
Address details

Department name
Address line 1
Address line 2
Town
Postcode

Tel: XXX
Fax: XXX
Email: xxx@wlmht.nhs.uk

Dear

You are entitled to request a copy of a letter written about you by a health professional employed by West London Mental Health NHS Trust. This may help you to have a better understanding of your healthcare needs and treatment plan. If you would like to receive copies of letters please complete the details below:

- I would like to receive copies of letters: ☐ Yes ☐ No
- I would like you to send copies of letters to my home address: ________________________________
- (delete if not applicable) ________________________________
- I would like my relative carer to receive copies: ☐ Yes ☐ No
- His/Her address is: ________________________________
- ________________________________
- ________________________________

Signed: _____________________________   Date: _________________

If letters are posted to you they will be marked as confidential. Please ensure that your address details are accurate and that you inform us of any change. It is your responsibility to keep your copy letters in a safe manner. If you are on a ward, your Primary Nurse can offer guidance about this. You can change your mind at any time if you no longer wish to receive copy letters.

You can ask for further guidance about this Trust policy and local procedures from any member of your care team or from PALs (the Trust Patient Advice & Liaison Service), tel 0800 064 3330

Yours sincerely