### ***Form II - Request for Release of Patient Identifiable Cancer Registry Data***

**(to be completed in conjunction with Form I)**

N. Ireland Cancer Registry

Centre for Public Health, Mulhouse Building,

Grosvenor Road, Belfast BT12 6DP

Tel: 028 9097 6028 Email: nicr@qub.ac.uk

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| 1. **Name and Title of Applicant:**(Please Use BLOCK CAPITALS)2. **Title of Study**3. **Are you currently the patient(s) consultant or General Practitioner?** | **YES/NO** |
| **(if yes, proceed to 7. Declaration)** |
| 4. **Have you (or have you ever had) clinical responsibility for the patient(s)?**If ‘No’ do you require a list of consultants from the N.I.C.R. whoWere responsible for the patients in your study? (Please note that we cannot release personal data for patients you are not, or never have been, responsible for unless we receive written permission from the consultants concerned.)5. **Is Ethical Committee approval required?**If ‘Yes’ please attach necessary confirmation of Ethical Committee’sapproval for study.**6. Has the patient’s consent been achieved?** | **YES/NO****YES/NO****YES/NO****YES/NO** |

**7. Declaration**

I understand that, in accordance with the Data Protection Act 1998, patient identifiable data is only released providing:

* + 1. The data is only used for the purpose for which they were supplied.
		2. The data is not passed on to any other persons or released into the public domain.
		3. The data is kept secure at all times.
		4. Any results of my work, which are disclosed, shall not be able to identify an individual.
		5. The data will not be kept longer that is necessary for the stated purpose and then shall be destroyed by shredding or burning by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)
		6. If I become aware of any loss or misuse of the data supplied to me I will inform the Director of the NICR immediately.
		7. If I am succeeded in my post with the research project my successor will require to complete a fresh declaration of confidentiality before receiving any further data.
		8. I confirm that data given to me will be used for the purpose for which they are supplied. I will give the NICR prior notice of any intended publication based on the data supplied and will acknowledge the NICR as the source of the data and the Public Health Agency which funds the Registry. I understand that unless the NICR has participated in the research, any interpretations will be acknowledged to be the author’s sole responsibility.

 Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF THE ABOVE SIGNED IS NOT MEDICALLY QUALIFIED PLEASE OBTAIN FURTHER SIGNATURE FROM A MEDICALLY QUALIFIED COLLEAGUE INVOLVED IN THE STUDY/WORK.

**DECLARATION BY MEDICALLY QUALIFIED PERSON** (If different from person named above)

In accordance with BMA guidelines for release of patient details I undertake to take responsibility for the confidentiality of any data supplied to my colleague involved in the study/work.

Name: (Please Print) ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Medical Qualification: \_\_\_\_\_\_\_\_\_\_\_\_ GMC Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_