**Application for Online Record Access**

**Name of person applying for access**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant Name |  | | |
| Date of Birth |  | | |
| Address |  | | |
| Home Telephone Number |  | | |
| Mobile Number |  | | |
| Email\* |  |  |  |

\*If this address is shared with others please consider whether you agree that it can be used to send you confidential information about your account. **This email address will be used to send you your registration letter which is needed to create your online account.**

**Name of all patients you are requesting access for (including yourself)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Name | Date of Birth | Age | Relationship to Applicant | Appointments / Prescriptions | Accessing Medical Record |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |
|  |  |  |  | Yes / No | Yes / No |

**Declaration**

|  |
| --- |
| 1. I have read and understood the information leaflet (Information for Patients) about access to GP medical records. |
| 1. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn. |
| 1. If I see information which does not relate the person I care for, I will immediately log out and report the matter to the practice as soon as possible. |
| 1. I agree that it is my responsibility to keep the username and passwords secure. If I think these have been shared inappropriately I will reset them using the instructions supplied and inform the practice. |
| 1. If I choose to share the information contained within my record I do so at my own risk. |
| 1. I am responsible for keeping safe any information I may print from the record. |
| 1. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. Please note, this does not affect your rights of Subject Access under the Data Protection Act. |
| 1. If I notice any inaccuracies with the record, I will inform the practice manager as soon as possible of any errors or omissions. |
| 1. I understand that I may see information on the record that I was unaware of / have forgotten about that could cause distress. |
| 1. I agree to inform the practice immediately if I no longer have responsibility for the patient’s care |

**This section MUST be signed in front of reception staff**

I agree to declarations 1 to 10 as shown above.

Applicant Signature…………………………..…………………………………Date..…………………

**For patients aged 11 and above this section MUST be signed in front of reception staff**

I agree that the applicant may have access as requested on the previous page

|  |  |
| --- | --- |
| Patient Name | Patient Signature |
|  |  |
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|  |  |

**Once this form has been fully completed and received by the practice please allow 5 working days to receive your registration letter. If you have not received it after this time, please contact the surgery.**

**Please note additional information may be required before access can be granted.**

***Please retain a copy of this form for your information.***

*Please remember to keep all your account details secure. If you think your account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service please speak to our practice manager.*

|  |  |
| --- | --- |
| **For practice use only** | |
| **Applicants ID verified by** (please circle which 2 documents were seen)  Driving Licence Mortgage Account Birth Certificate  Passport Rental Agreement Telephone Bill  Bank Statement National 60+ Bus Pass Insurance Document  Utility bill Loan Account NoW card  Other document (please specify)  Vouching  Vouching with information in record | |
| **Applicants proof of their right to access the patients record** (please circle which document was seen)  Patient’s birth certificate Residence / Special Guardianship order  Patient’s adoption certificate Emergency Protection order  Parental responsibility agreement Power of Attorney document  Other (please specify) | |
| **Staff Name:** | **Date:** |