Online Application Form

Application form for access to the practice’s online services

This form is to be used by a patient of any age to request access to the practice online services. Not all sections will be relevant to all patients, please read carefully and complete those you need to. If you require any assistance in completing this form, please see a member of the reception team

Please answer the following and then go to the relevant sections:

|  |  |
| --- | --- |
| I want online access to practice services for myself and I am over 16 years old  If Y please download and request access using NHS App  If you don’t have the ability to do this, please continue with this form and complete: Sections 1, 5 | Y / N |
| I want online access to practice services for myself and I am under 16 years old  If Y please complete: Sections 2, 5 | Y / N |
| I want to access online practice services on behalf of someone else (by proxy). This could be for a child or another adult.  If Y please complete: Sections 3, 4, 5 | Y / N |

**Section 1: The patient (Over 16 years old)**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

**Section 2: The patient (Under 16 years old)**

(This is the person whose records are being accessed)

I understand that, if I am under the age of 16, this request will be reviewed by a doctor who will decide if access can be granted. I understand that I will be notified by the surgery once a GP has reviewed by application to let me know if it has been granted or not.

|  |  |
| --- | --- |
| Patient Name |  |
| Patient Age and Date of Birth | Age:\_\_\_\_\_\_\_\_\_\_\_ DoB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Signature |  |

**Section 3: Proxy access request**

**The patient whose records you want access to**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

**Section 4: Patient permission that the representative(s) can have access**

(for adults with capacity and children 11 years old and above)

I,………………………………………………….. (name of patient), give permission to my GP practice

to give the following people ….………………………………………………………………..……………..

proxy access to the online services as indicated below in section 5

I reserve the right to reverse any decision I make in granting proxy access at any time.

I understand the risks of allowing someone else to have access to my health records.

I have read and understand the information leaflet provided by the practice

|  |  |
| --- | --- |
| Signature of patient | Date |

Note: If patient does not have capacity to sign this section, please provide reason in box above in place of the signature

**The representatives**

(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription. This could be for another child or adult)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| Address  Postcode | Address (tick if both same address 🞏)  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |
| Relationship to patient who you want online access for | Relationship to patient who you want online access for |

**Section 5: Access and responsibilities**

**Access required**

|  |  |
| --- | --- |
| Please tick which online services are required: | |
| 1. Booking appointments | □ |
| 2. Requesting repeat prescriptions | □ |
| 3. Accessing my medical record | □ |

**Responsibility of online access (continued overleaf….)**

|  |  |
| --- | --- |
| I understand and agree with each statement (tick).  If this access is for yourself it applies to your records, if this access is for someone else, it applies to their records | |
| 1. I will be responsible for the security of the information that I see or download | □ |
| 2. I will be responsible for the security of the information that I see or download | □ |
| 3. If I choose to share the information with anyone else, this is at my own risk | □ |
| 4. If I suspect that the account has been accessed by someone without my agreement, I will contact the practice as soon as possible | □ |
| 5. If I see information in the record that is not about me (or the patient) or is inaccurate, I will contact the practice as soon as possible | □ |
| 6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. | □ |
| Signature of patient or all representative(s)  Patient / Representative 1: Representative 2: (if applicable) | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| For practice use only | | |  |
| Patient NHS number | | d.o.b. | |
| Identity verified by (initials)  Date | Method used | Vouching □  Vouching with information in record □ Photo ID and proof of residence □ | |
| Documentary evidence provided | |  | |
| Access / Proxy Access Authorised by | | Date | |
| Date account created | | | |
| Date login credentials emailed/given | | | |
| Level of record access enabled    Prospective 🞏  Retrospective 🞏  All 🞏  Limited parts 🞏  Contractual minimum 🞏 | | Notes / explanation | |
| Under 16 requesting access in own name.  Competency Authorised by | | Date  Competent. Read code XaKIJ  Not Competent. Read code XaXLv | |
| Reason for refusal if record access is refused after clinical review | | | |