

# REQUEST TO ONLINE SERVICES



Countesthorpe  
Health Centre

In accordance with the UK General Data Protection Regulation (UK GDPR)

## Guidance notes – please read before completing this form:

A patient aged over 13 and below 18 must give permission for their parents/carer to have proxy access to their records, if they have capacity to.

If a child aged 13 or over has 'sufficient understanding and intelligence to enable him/her to understand fully what is proposed' (known as Gillick Competence), then s/he will be competent to give consent for him/herself but may wish a parent to countersign as well. This will be assessed by a GP after the form has been completed.

The patient requesting/being given proxy access must be registered at the surgery.

## Tick the option you are applying for and complete those sections:

- Patients requiring access to their own record (Sections 1, 2 and 8)
- Parents requesting access to their child's, under 13, record (Sections 1, 3, 6, 7 and 8)
- Proxy access to health records where patient has capacity (Sections 1, 4, 6, 7 and 8)
- Proxy access to health records where patient does not have capacity (Sections 1, 5, 6, 7 and 8)

## Section 1:

Patient details

Surname		Former name	
Forename		Title	
Date of birth		Address:	
Mobile		Postcode:	
Email (Block capitals)			
NHS number (if known)		Hospital number (if known)	

## Section 2:

### Record requested

I wish to have access to the following online services (please tick all that apply):

Booking appointments	<input type="checkbox"/>
Requesting repeat prescriptions	<input type="checkbox"/>
Access to my medical records	<input type="checkbox"/>

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

I have read and understood the information leaflet provided by the organisation <a href="https://www.countesthorpehealthcentre.co.uk/practice-information/register-for-online-access/">https://www.countesthorpehealthcentre.co.uk/practice-information/register-for-online-access/</a>	<input type="checkbox"/>
I understand that I will automatically see any new information (prospective records) that is added to my healthcare record.	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible	<input type="checkbox"/>

Patient signature		Date	
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## Section 3:

### Parental access – Under 13 years old

I/We wish to have access to the health records on **behalf of** the named patient in section 1 as I/we have parental responsibility:

Surname		Surname	
First name		First name	
Date of birth		Date of birth	
Address		Address	
Postcode		Postcode	
Email		Email	
Telephone		Telephone	
Mobile		Mobile	

## Section 4:

### Consent to proxy access to GP Online Services (if patient has capacity)

- I..... (name of patient), give permission to my GP practice to give the following person/people ..... proxy access to the online services as indicated below in Section 6
- 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 organisation

<b>Patient signature</b>		<b>Date</b>	
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I/We wish to have access to the health records on **behalf of** the above-named patient

<b>Surname</b>		<b>Surname</b>	
<b>First name</b>		<b>First name</b>	
<b>Date of birth</b>		<b>Date of birth</b>	
<b>Address</b>		<b>Address</b>	
<b>Postcode</b>		<b>Postcode</b>	
<b>Email</b>		<b>Email</b>	
<b>Telephone</b>		<b>Telephone</b>	
<b>Mobile</b>		<b>Mobile</b>	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

**Reason for access:**

I have been asked to act by the patient	<input type="checkbox"/>
I have full parental responsibility for the patient and the patient is under the age of 18 and has consented to my making this request	<input type="checkbox"/>

## Section 5:

Consent to proxy access to GP Online Services (if patient does not have capacity)

I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		Surname	
First name		First name	
Date of birth		Date of birth	
Address		Address	
Postcode		Postcode	
Email		Email	
Telephone		Telephone	
Mobile		Mobile	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper).

### Reason for access:

I/We have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	<input type="checkbox"/>
I am/We are acting <i>in loco parentis</i> and the patient is incapable of understanding the request	<input type="checkbox"/>
I am/We are the deceased person's personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration)	<input type="checkbox"/>
I/We have written and witnessed consent from the deceased person's personal representative and attach Proof of Appointment	<input type="checkbox"/>
I/We have a claim arising from the person's death (please state details below)	<input type="checkbox"/>

## Section 6:

Proxy access online services available

I/We wish to have access to the following online services (please tick all that apply):

Booking appointments	<input type="checkbox"/>
Requesting repeat prescriptions	<input type="checkbox"/>
Access to my medical records	<input type="checkbox"/>

## Section 7:

### Proxy declaration

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement (tick)

I/We have read and understood the information leaflet provided by the organisation and agree that I/we will treat the patient information as confidential <a href="https://www.countesthorpehealthcentre.co.uk/practice-information/register-for-online-access/">https://www.countesthorpehealthcentre.co.uk/practice-information/register-for-online-access/</a>	<input type="checkbox"/>
I/We will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
I/We will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	<input type="checkbox"/>
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential	<input type="checkbox"/>

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the [Data Protection Act 2018](#).

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

<b>Applicant signature</b>		<b>Date</b>	
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## Section 8:

### Proof of identity

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up. Proof of care/parental responsibility will be needed for access to a child's record under 13 or this will need to be documented on their record prior to completing this form.

Please speak to reception if you are unable to provide this.

#### **ADDITIONAL NOTES:**

Before returning this form, please ensure that you have:

- Signed and dated the form
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
- Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.

**For office use only:**

**Identification verification must be verified through two forms of ID**

- One must contain a photo (e.g., passport or photo driving licence) and bank statement
- When this is not available, vouching by a member of staff or by confirmation of information in the records by one of the management team or a partner may be used

<b>Request received</b>		Request refused	
Request reviewed		Request completed	
Comments			
<b>Identification of</b>	<input type="checkbox"/> Patient	<input type="checkbox"/> Parental responsibility	<input type="checkbox"/> Applicant
<b>Identity verified by</b>		<b>Date</b>	
<b>Identity method</b>	<input type="checkbox"/> Photo ID or proof of residence – Type ..... <input type="checkbox"/> Photo ID or proof of residence – Type ..... <input type="checkbox"/> Proof of parental responsibility – Type ..... <input type="checkbox"/> Vouching – by whom ..... <input type="checkbox"/> Vouching with information in record – by whom ..... <input type="checkbox"/> Vouching with parental responsibility in record – by whom .....		
Proxy access authorised by			
Proxy access coded in notes	<input type="checkbox"/> Yes	NHS/EMIS No:	
Date account created		Date password sent	
Level of access enabled	<input type="checkbox"/> All	<input type="checkbox"/> Prospective	<input type="checkbox"/> Retrospective <input type="checkbox"/> Limited parts
Notes for proxy access <i>(If any request is refused, discuss with the organisation's DPO before informing patient/applicant)</i>			