**Child Application for Online Access to Medical Records**

**(Under 12 proxy access)**

**Details of child**

|  |  |
| --- | --- |
| Surname | Date of Birth |
| First Name | |
| Address      Postcode | |
| Email Address | |
| Telephone Number | Mobile Number |

**Details of Parent/ Guardian requesting access**

|  |  |
| --- | --- |
| First Name: | Surname: |
| Date of Birth: | Relationship to patient: |
| Are you registered at our organization? Yes / No | |
| Address:      Postcode: | |
| Email Address: | |
| Telephone Number: | Mobile Number: |

**The following access to be granted**

**(Please tick all that apply):**

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat prescriptions |  |
| Access to tests results |  |
| Prospective full medical record |  |

**Please tick and sign that you understand and agree with each statement:**

|  |  |
| --- | --- |
| I have read and understood the “Accessing your GP-held records via the NHS app or NHS website information” on the Acorn Surgery website and understand the risks involved. | 🞏 |
| I understand that I am responsible for the security of any information that is seen, downloaded or printed | 🞏 |
| If I choose to share my child’s information with anyone else, this is at my own risk | 🞏 |
| I will contact the practice as soon as possible if I suspect my account has been accessed by someone without my agreement | 🞏 |
| If I see information in my child’s record that is not about them or is inaccurate, I will contact the practice as soon as possible | 🞏 |
| I agree to use the system in a responsible manner. If not access may be withdrawn. | 🞏 |
| I agree that it is my responsibility to keep my username and password secure. If I think these have been shared inappropriately, I will take the appropriate action, reset the password and inform the Practice. | 🞏 |
| I understand that I may see information on my child’s record that I was unaware of or have forgotten about that could cause me distress. | 🞏 |
| I understand that, I will be informed by the Practice of any test results that require action. However, I understand I may see these results online before the Practice has been able to contact me. This could be while the Surgery is closed and there is no one available to discuss with me. | 🞏 |
| I understand that I may see information that relates to significant diagnosis before the GP or hospital specialist has had the opportunity to discuss with me  This may relate to diagnosis, prognosis and treatment options and that this may cause me distress. | 🞏 |
| I understand that there may be medical terminology used within my child’s records that I do not understand and that it will take time to arrange for a member of the team to be able to explain the relevant terminology with me and that this could cause me distress. | 🞏 |

I understand that the following access will be revoked when the child reaches the age of 12, at which point a new request will need to be submitted by them should they wish for my proxy access to be reinstated.

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | |  | |
| Identity verified by  (initials) | Date | Method  Vouching 🞏  Vouching with information in record 🞏 Photo ID and proof of residence 🞏 | |
| Authorised by | | | Date |
| Date account created | | | |
| Details of Proxy verified | | Proxy registered at our organisation | |
| When will child be 12?  (Set end date for 12th birthday) | |  | |
| Level of record access enabled  Appointment booking 🞏  Medication requests 🞏  Medical records 🞏 | | Notes / explanation | |