

**ONLINE SERVICES REGISTRATION – STANDARD AND PROXY ACCESS**

**Please carefully read this information sheet. You should keep the information sheets for future reference and only return the registrations forms. You will be asked to confirm you have read and understood this information on your registration form.**

You can view, book, and cancel appointments, as well as order your repeat medication, and access your medical records online. You will need to choose which services you wish to access, as well as how you access them.

There are a number of options available for online access. The preferred way is to register using the NHS App. The App is available to anyone who has a smartphone or tablet and is over 13. If you wish to use the NHS App, you can self-register for online access to appointments, prescriptions, and all future medical records. If you wish to access your historic medical record, you will need to complete the form overleaf.

If you cannot use the NHS App, some other choices are: *(more options are in the email received after registration)*

|  |  |
| --- | --- |
| * **Patient Access**
 | * **Co-op Health**
 |
| * **Evergreen life**
 | * **Digi.me (App for medical records-coming soon**
 |
| * **The Waiting Room**
 | * **Patient Services**
 |

To request your details to access any of these options, **please complete the form overleaf and bring the completed form and ID into the surgery.** One of the IDs will need to be a valid photo ID, such as a passport or driving license. The other will need to be proof of address, such as a utility bill from within the last 6 months, or a bank statement. This will be needed for each individual wishing to register, regardless of whether you have shown the surgery ID before.

We ask for this documentation because this process will grant you access to your confidential medical records, and we want to ensure we are only doing this for the right person.

Upon completion of this form, your request will be reviewed by the practice. If there is any reason why your request is declined, your GP will put this in writing to you. Otherwise, you will be issued your access codes by email**. Please allow up to 28 working days for your full request to be processed**, though prescription/appointment access is generally processed within 5 working days.

Please be aware, if you have only recently registered with the practice, the medical record details available to you may be limited until we receive your paper notes to put on the system. This can take many months.

**If you are aged 16+ and want to register for your own access, please complete the “Standard Access” form attached.**

**If you are aged 16+ and want to have a representative manage your account on your behalf, please complete the “Proxy Access Part 1 & Part 2” forms.**

**If you are a parent/guardian of a patient aged 0-10 and want to access their account, please complete the “Proxy Access Part 1” form ONLY.**

**If you are aged 11-15, we cannot currently offer online access to you either as standard access or proxy access. Please see our website for full details: https://www.hedgeendmedicalcentre.co.uk/how-to-register-for-patient-access**

**Patients aged 12-15 needing a Covid pass can request a digital or paper copy from** [**www.nhs.uk**](http://www.nhs.uk) **(search Covid pass)**

**IMPORTANT INFORMATION**

Being able to see your record online might help you to manage your medical conditions. It also means that you can even access it from anywhere in the world should you require medical treatment on holiday. If you decide not to join or wish to withdraw, this is your choice and practice staff will continue to treat you in the same way as before. This decision will not affect the quality of your care.

Your unique login details ensure that only you are able to access your record – unless you choose to allow “proxy access” to a family member or carer. It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can’t do this for some reason, we recommend that you contact the practice as soon as possible so that we can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

**The practice has the right to remove online access to services for anyone that doesn’t use them responsibly.**

**THINGS TO CONSIDER**

Before you apply for online access to your record, there are some other things to consider. Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

**Forgotten history**

There may be something you have forgotten about in your record that you might find upsetting.

**Abnormal results or bad news**

If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

**Choosing to share your information**

It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep information safe and secure.

**Coercion**

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

**Misunderstood information**

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be technical and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

**Information about someone else**

If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

**MORE INFORMATION**

For more information about keeping your healthcare records safe and secure, view a helpful leaflet produced by the NHS in conjunction with the British Computer Society: “Keeping your online health and social care records safe and secure” - <http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf>

**STANDARD ACCESS FORM:**

Please complete the form **clearly** and in **BLOCK CAPITALS**

I wish to register for online services:

|  |  |
| --- | --- |
| **Forename:**       | **Surname:**       |
| **Date of Birth:**       |  |
| **Email address:**       | **Home telephone number:**       |
| **Mobile telephone number:**       | **Work telephone number:**       |

*By providing your email address / mobile phone number, you consent to the surgery using it to communicate with you regarding your healthcare. It will not be shared with any other companies, and you can opt out of Online Services and communication by email / SMS at any time by contacting the surgery.*

**PLEASE REMEMBER IT IS YOUR RESPONSIBILITY TO KEEP THE SURGERY INFORMED IF YOUR EMAIL ADDRESS OR TELEPHONE NUMBERS CHANGE.**

I request access to the following services online:

*(Please tick each section you would like access)*

**[ ]  View, Book, and Cancel Appointments**

**[ ]  Order Repeat Prescriptions**

**[ ]  View Future Medical Records**

**[ ]  View Historic Medical Records**

I understand and agree with each statement below (tick):

|  |  |
| --- | --- |
| I have read and understood the information overleaf provided by the practice | [ ]  |
| I will be responsible for the security of the passwords / pin numbers in relation to my online account | [ ]  |
| I will be responsible for the security of the information that I see or download | [ ]  |
| If I choose to share my information with anyone else, this is at my own risk | [ ]  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | [ ]  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | [ ]  |
| 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 | [ ]  |
| I understand and agree that the practice has the right to remove my online access to any part of the Online Services if they are not used responsibly | [ ]  |
| I understand that the rules surrounding Online Services may change at any time | [ ]  |

I have read and understood the information above and would like to request access to the online services.

|  |  |
| --- | --- |
| **Signed** | **Date** |
|       |       |

**PROXY ACCESS FORM - Part 1 (Representative):**

Please complete the form **clearly** and in **BLOCK CAPITALS**

I (the representative) wish to have online access:

|  |  |
| --- | --- |
| **Forename:** | **Surname:** |
| **Date of Birth:** | **Relationship:** |
| **Email address:**       | **Home telephone number:**       |
| **Mobile telephone number:**       | **Work telephone number:**       |

*By providing your email address / mobile phone number, you consent to the surgery using it to communicate with you regarding your healthcare. It will not be shared with any other companies, and you can opt out of Online Services and communication by email / SMS at any time by contacting the surgery.*

**PLEASE REMEMBER IT IS YOUR RESPONSIBILITY TO KEEP THE SURGERY INFORMED IF YOUR EMAIL ADDRESS OR TELEPHONE NUMBERS CHANGE.**

I wish to have proxy access for:

|  |  |
| --- | --- |
| **Forename:**       | **Surname:**       |
| **Date of Birth:**       |  |

For the following services:

*(Please tick each section you would like access)*

**[ ]  View, Book, and Cancel Appointments**

**[ ]  Order Repeat Prescriptions**

**[ ]  View Future Medical Records**

**[ ]  View Historic Medical Records**

I understand and agree with each statement below (tick):

|  |  |
| --- | --- |
| I understand my responsibility for safeguarding sensitive medical information | [ ]  |
| I will not disclose the log in details or allow access to anyone else or any third party | [ ]  |
| I will be responsible for the security of the information that I see or download | [ ]  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed by someone without my/our agreement | [ ]  |
| If I see information in the record that is not about the patient, or is inaccurate, I will contact the practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential | [ ]  |
| I confirm that I have discussed the implications of my accessing the records with the patient and shown them the information form. | [ ]  |
| 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 | [ ]  |
| I understand and agree that the practice has the right to remove my online access to any part of the Online Services if they are not used responsibly | [ ]  |
| I understand that the rules surrounding Online Services may change at any time | [ ]  |

I have read and understood the information above and would like to request access to the online services.

|  |  |
| --- | --- |
| **Signed** | **Date** |
|       |       |

**PROXY ACCESS FORM - Part 2 (Patient - 16yrs+ ONLY):**

Please complete the form **clearly** and **in BLOCK CAPITALS**

I (the patient) wish to give permission for proxy access to my account:

|  |  |
| --- | --- |
| **Forename:**       | **Surname:**       |
| **Date of Birth:**       |  |

I wish to give permission for proxy access to:

|  |  |
| --- | --- |
| **Forename:**       | **Surname:**       |
| **Date of Birth:**       | **Relationship:**       |

For the following services:

*(Please tick each section you would like access)*

[ ]  **View, Book, and Cancel Appointments**

**[ ]  Order Repeat Prescriptions**

**[ ]  View Future Medical Records**

**[ ]  View Historic Medical Records**

I understand and agree with each statement below (tick):

|  |  |
| --- | --- |
| 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 | [ ]  |

 I have read and understood the information above and would like to request proxy access to my online services.

|  |  |
| --- | --- |
| **Signed** | **Date** |
|       |       |

**STAFF USE ONLY**

**Reception Staff:** Review registration form and complete the appropriate sections below:

**[ ]  Standard Access**

**[ ]  Proxy Access**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Form Completed?** | [ ]  |  | **Part 1 Form Completed?** | [ ]  |
| **Services Ticked?** | [ ]  |  | **Services Ticked?** | [ ]  |
| **Consent Ticked?** | [ ]  |  | **Consent Ticked?** | [ ]  |
| **Signed & Dated?** | [ ]  |  | **Signed & Dated?** | [ ]  |
|  | **Part 2 Form Completed? *(16+)*** | [ ]  |
|  | **Services Ticked? *(16+)*** | [ ]  |
|  | **Consent Ticked? *(16+)*** | [ ]  |
|  | **Signed & Dated? *(16+)*** | [ ]  |
| **Patient Photo ID Seen?**Type:      Seen By:       | [ ]  |  | **PATIENT ID Seen? (doesn’t have to be photo ID)**Type:      Seen By:       | [ ]  |
|  | **REPRESENTATIVE Photo ID Seen?** Type:      Seen By:       | [ ]  |
| **(If for medical records):** **Address ID Seen?**Type:      Date of letter:      Seen By:       | [ ]  |  | **(If for medical records):** **REPRESENTATIVE** **Address ID Seen?**Type:      Date of letter:      Seen By:       | [ ]  |

Once this section is completed, please put into tray in reception.

(The information part of this document is to stay with the patient)

**Admin Staff:** Task GP & record review of the patient’s record.

|  |  |  |
| --- | --- | --- |
| **Historic Medical Record****Permission Granted**(🗸 / 🗴) | **Name of who Reviewed Patients Notes** | **Date Reviewed** |
|  |  |  |
| **If Permission was NOT Granted,****Please give a brief reason why?** |  |

If permission has been granted, add the ‘electronic records verified’ code and amend the patients DCR details in Registration.

If permission has been declined, write to the patient to inform them of this and why.

|  |  |  |
| --- | --- | --- |
| **Online Services Status Updated or Letter Sent** | **Actioned By** | **Date Actioned** |
|  |  |  |