**Application for online access to my medical record**

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

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

|  |  |
| --- | --- |
| 1. Managing appointments
 |  |
| 1. Requesting repeat prescriptions
 |  |
| 1. \*Viewing my medical record (medication, allergies, immunisations, consultations, documents & test results)

**\*Viewable online medical records are subject to their availability on the electronic clinical system. Viewable online medical records apply prospectively from the date of 29th November 2023, unless specified directly in writing to the practice that retrospective record access is requested. If you are a registered patient after 29th November 2023, medical records are instead viewable from the date of registration and onwards.** |  |

**I wish to access my medical record online and understand and agree with each statement (tick)**

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see, and if able to, download
 |  |
| 1. If I choose to share my information with anyone else, this is at my own risk
 |  |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 |  |

|  |  |
| --- | --- |
| Signature: | Date: |

***For practice use only:* TO BE COMPLETED BY RECEPTION**

|  |  |
| --- | --- |
| Patient NHS number: | Method (please tick): |
| Identity verified by (initials): | Date: |  | Vouching |
|  | Vouching with information in record |
|  | Photo ID and proof of residence |

***For practice use only:* TO BE COMPLETED BY MANAGER**

|  |  |
| --- | --- |
| Authorised by: | Date: |
| Level of record access enabled (please tick): | Notes/Explanation |
|  | Prospective |
|  | All (Prospective & Retrospective) |
|  | Limited parts |

**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 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 organisation

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient signature** |  | **Date** |  |

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 have been asked to act by the patient  | 🞏 |
| 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  | 🞏 |
| I have full parental responsibility for the patient and the patient is under the age of 18 and is incapable of understanding the request | 🞏 |

**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 |  🞏 |
| I/We are acting *in loco parentis* and the patient is incapable of understanding the request | 🞏 |

**Section 1: Proxy access online services available**

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

|  |  |
| --- | --- |
| Managing appointments | 🞏 |
| Requesting repeat prescriptions | 🞏 |
| \*Viewing my medical record (medication, allergies, immunisations, consultations, documents & test results)**\*Viewable online medical records are subject to their availability on the electronic clinical system. Viewable online medical records apply prospectively from the date of 29th November 2023, unless specified directly in writing to the practice that retrospective record access is requested. If you are a registered patient after 29th November 2023, medical records are instead viewable from the date of registration and onwards.** | 🞏 |

**Section 2: 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 | 🞏 |
| I/We will be responsible for the security of the information that I/we see and if able to, download | 🞏 |
| 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 | 🞏 |
| 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 | 🞏 |

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](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted).

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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant signature** |  | **Date** |  |

**Section 3: Proof of identity**

Under the [Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted), 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.

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 of which must contain a photo e.g., passport, photo driving licence or bank statement

Where 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

|  |  |  |  |
| --- | --- | --- | --- |
| Request received |  | Request refused |  |
| Reviewed by Staff Member |  | Request completed |  |
| Identification of | 🞏 Child (aged 13-17) | 🞏 Patient | 🞏 Applicant |
| Identity verified by |  | Date |  |
| Identity method | 🞏 Photo ID or proof of residence – Type ………………………………..🞏 Photo ID or proof of residence – Type ………………………………..🞏 Vouching – by whom ……………………………………………………🞏 Vouching with information in record – by whom …………………… |
| Proxy access authorised by |  |
| Proxy access coded in notes | 🞏 Yes | NHS/EMIS No: |  |
| Date account created |  | Date password sent |  |
| Level of access enabled | □ All | □Prospective | □ Retrospective | □ Limited parts |
| Notes for proxy access*(If any request is refused, discuss with the organisation’s DPO before informing patient/applicant)* |  |