

***THE GLENFIELD SURGERY***

**Application for online access**

Please supply two forms of identification with this form (one photo and one utility bill)

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

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

|  |  |
| --- | --- |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record (**Medication and Allergies Only**)
 | 🞏 |
| 1. If you want access to the ‘Detailed Coded Records’ (DCR)
 | 🞏 |

# PLEASE READ AND AGREE TO THE ‘TERM AND CONDITIONS’ BELOW

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or 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.
 | 🞏 |
| 1. That I am requesting access of my own free will and am not being coerced by a third party.
 | 🞏 |
| **If you require online access to medical records in the capacity of parent/guardian to someone under the age of 11, please complete below** |
| 1. I understand that as the parent/guardian of a child I will only have access until the child reaches the age of 11 then my access rights are withdrawn.
 | 🞏 |
| **If you require online access to medical records in the capacity of carer or otherwise and children aged 11-16, please complete the attached for ‘Patient proxy access’.** |  |

**Please RETURN form to front desk of reception ande supply two forms of identification with this form (one photo and one utility bill). After you complete this form please download the SystmOnline App if you have a smart phone device**

|  |  |
| --- | --- |
| Signature of Patient / Parent / Guardian (please indicate) | Date: |

|  |  |
| --- | --- |
| **Patient NHS number**: |  |
| **Identity Verified by** (**staff initials):** | **Date:** | **Form of ID:**Photo ID :Proof of Residence :  |
| **Scanned onto Patient’s Records**:  | **Date:** |

**For Practice Use On**



***THE GLENFIELD SURGERY***

**APPLICATION FOR PROXY ACCESS TO ONLINE SERVICES FOR ADULTS AND**

**CHILDREN AGED 11 - 16.**

**Patient details:**

**Surname …………………………………........ Forename ……………………………………..…………**

**Date of birth ………………………………….. NHS number ………………………………….…………**

**Address …………………………………………………………………………………………………………...**

**………………………………………………………………………………………………………………………**

**Telephone ………………………………………….. GP details ……………………………………..**

**Nominated individual details:**

**Surname …………………………………...... Forename ……………………………………..…………**

**Date of birth ………………………………… NHS number ………………………………….………….**

**Address …………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………..**

**Telephone …………………………… GP & practice details ……………………………………………**

**Relation to patient ……………………………………………………………………………………………….**

I give permission for my nominated individual to have proxy access to the online services as detailed below:

|  |  |
| --- | --- |
| 1. Booking appointments
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. Accessing my medical record
 | 🞏 |

**I am aware that my GP may overrule my decision at any time and that this authorisation will remain in force until …./…./…. or until cancelled by me (in writing). I understand the risks of allowing someone else access to the online services detailed above.**

|  |  |
| --- | --- |
| Signature (of patient) | Date: |

**I agree that I will treat all the information confidentially and will not disclose this information to any third party without the expressed permission of the person named as the patient above. I will only use this information in the best interest of the patient.**

|  |  |
| --- | --- |
| Signature (of nominated Individual) | Date: |

**FOR PRACTICE USE ONLY**

|  |  |
| --- | --- |
| **Patient NHS number**: |  |
| **Level of record access enabled: All**  □ **Prospective**  □**Retrospective**  □ **DCR**  □ **Limited parts**  □ | **Notes/explanation**  |
| **Identity Verified by** (**staff initials):** | **Date:** | **Form of ID:**Photo ID :Proof of Residence : |
| **Authorised by** | **Date:** |