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. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

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	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. 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

Consent to proxy access to GP online services

Section 1

I/we,…… (name of patient), give permission to my GP practice to give the following people …….. proxy access to the online services as indicated below in section 2.

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

Signature of patient	Date

Section 2

Online appointments booking	☐
Online prescription management	☐
Accessing the medical record for (name of patient)	☐

Section 3

I/we…….. (names of representatives) wish to have online access to the services ticked in the box above in section 2
for …… (name of patient).
I/we understand my/our responsibility for safeguarding sensitive medical information and I/we understand and agree with each of the following statements:

I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential	☐
I/we will be responsible for the security of the information that I/we see or 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 practice as soon as possible. I will treat any information which is not about the patient as being strictly confidential	☐

Signature/s of representative/s	Date/s

For practice use only

Patient NHS number		Practice computer ID 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			
Date passphrase sent			
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed ☐ Limited parts ☐ Contractual minimum ☐		Notes / explanation	