

Application form for access to the practice online services online

Please note:

- 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. Access can also be gained on some phones using fingerprints or Face ID – please consider this.
- If you have concerns about this, we recommend that you contact the practice so that they 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 may not be able to offer online access due to a number of reasons such as concerns that it could cause harm to physical or mental health or where there is reference to third parties. The practice has the right to remove online access to services for anyone they feel it could harm or be put at risk.

Key considerations

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 with someone 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 the 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 highly technical, written by specialists 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.

In accordance with the UK General Data Protection Regulation (UK GDPR)

Guidance notes – please read before completing this form:

If a child aged 13 or over has 'sufficient understanding and intelligence to enable him/her to understand fully what is proposed' (known as Gillick Competence), then s/he will be competent to give consent for him/herself but may wish a parent to countersign as well.

- **Patients requiring access to their own record** (Sections 1, 2 & 7)
- **Proxy access to health records where patient has capacity** (Sections 1, 3, 5, 6 & 7)
- **Proxy access to health records where patient does not have capacity** (Sections 1, 4, 5, 6 & 7)
- **Parents requiring access to their child's** (age 13-17) record (Sections 1, 3, 5, 6 & 7)

Section 1: Patient details

Surname		Former name	
Forename		Title	
Date of birth		Address:	
Telephone number		Postcode:	
NHS number (if known)		Hospital number (if known)	

Section 2: Record requested

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

My medical record (Summary – incl allergies, sensitivities, medication. Detailed Coded – as above + results, diagnoses, problems, vaccinations)	<input type="checkbox"/>
Full clinical record access (applicable from the date of request)	<input type="checkbox"/>
Full clinical record access (retrospective access from the date electronic patient access is available)	<input type="checkbox"/>

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

I have read and understood the information leaflet provided by the organisation	<input type="checkbox"/>
I understand that I will automatically see any new information (prospective records) that is added to my healthcare record.	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible	<input type="checkbox"/>

Patient signature		Date	
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Section 3: 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	
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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	<input type="checkbox"/>
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 or is incapable of understanding the request (delete as appropriate)	<input type="checkbox"/>

Section 4: 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	<input type="checkbox"/>
I am/We are acting <i>in loco parentis</i> and the patient is incapable of understanding the request	<input type="checkbox"/>
I am/We are the deceased person's personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration)	<input type="checkbox"/>
I/We have written and witnessed consent from the deceased person's personal representative and attach Proof of Appointment	<input type="checkbox"/>
I/We have a claim arising from the person's death (please state details below)	<input type="checkbox"/>

Section 5: Proxy access online services available

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

Medical record (Summary – incl allergies, sensitivities, medication. Detailed Coded – as above + results, diagnoses, problems, vaccinations)	<input type="checkbox"/>
Full clinical record access (applicable from the date of request)	<input type="checkbox"/>
Full clinical record access (retrospective access from the date electronic patient access is available)	<input type="checkbox"/>

Section 6: 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	<input type="checkbox"/>
I/We will be responsible for the security of the information that I/we see or download	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>

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](#).

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	
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Section 7: Proof of identity

[Under the Data Protection Act 2018, 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 must contain a photo (e.g., passport or photo driving licence) and bank statement
- When 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 HCP		Request completed	
Comments			
Identification of	<input type="checkbox"/> Child (aged 13-17)	<input type="checkbox"/> Patient	<input type="checkbox"/> Applicant
Identity verified by		Date	
Identity method	<input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Vouching – by whom <input type="checkbox"/> Vouching with information in record – by whom		
Proxy access authorised by			
Proxy access coded in notes	<input type="checkbox"/> Yes	NHS/EMIS No:	
Date account created		Date password sent	
Level of access enabled	<input type="checkbox"/> All	<input type="checkbox"/> Prospective	<input type="checkbox"/> Retrospective <input type="checkbox"/> Limited parts
Notes for proxy access <i>(If any request is refused, discuss with the organisation's DPO before informing patient/applicant)</i>			