# Application for online access

If a child aged 13 or over has ‘sufficient understanding and intelligence to enable them to understand fully what is proposed’ (known as Gillick Competence), then they will be competent to give consent for themself but may wish a parent to countersign as well.

Please provide photographic identification with this form. This will be required before access can be set up.

|  |  |
| --- | --- |
| 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
 | 🞏 |
| 1. Requesting repeat prescriptions
 | 🞏 |
| 1. 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
 | 🞏 |
| 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
 | 🞏 |

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

### For practice use only

|  |
| --- |
| Patient NHS number |
| Identity verified by(initials) | Date | MethodVouching 🞏Vouching with information in record 🞏 Photo ID and proof of residence 🞏 |
| Authorised by  | Date |
| Date account created  | Date password sent |
| Access to Online Services Consented by Patient Read code added (Y429b): |
| Level of record access enabledProspective 🞏Retrospective 🞏 All 🞏Limited parts 🞏Contractual minimum 🞏 | Notes /comments: |