**Electronic Health Record Access**

**Consent Form**

**Please note: separate consent forms for each individual is required and needs to be completed by the individual unless \*proxy consent is required**

* I have read and understood the information leaflet about access to my Electronic Health Record using the internet.
* I request permission from my GP practice for access to my Electronic Health Record using the internet.
* I agree to follow the instructions I am given by my GP practice and to immediately report any mistakes I find when using the Electronic Health Record.
* If I see anyone else’s information I will immediately log out of the system and report it to the GP practice and will **not** share this information.

**Section A:** Please complete this section if you are the patient requesting access for yourself *(If you are not the patient, please complete this section and then go to section B)*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B:** Please complete this section if you are requesting \*proxy access. (If the patient is aged 16years+, a third party consent is required to be completed before access is authorised)

Name of representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a patient at Oldham Medical Services? *(Circle the response)* Yes No

Are you already a user of Patient services? *(Circle the response)* Yes No

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| **For office use only**  **ID: Information Leaflet Provided: Yes No**  **Date Received: Received By:**  *(Please circle the requested fields below)*  **Appointments Prescriptions Medical Records** (16+only)  *\*\*\* If a patient is requesting access to* ***medical records*** *please provide them with the questionnaire. It is compulsory for patient to complete this before access is authorised \*\*\** |