**Allied Medical Practice**

**(School House & Church Surgery)**

**Application & Consent for Online Access to Detailed Medical Records**

 **(OVER 16’S ONLY & No Proxy Access)**

You can now view your GP medical record online to look at test results, details of consultations and your medical history, including current and past medication.

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information about you (provided below) to set up the and operate the service.

The following form will take you through the things you need to think about. By signing the form you will be giving us your permission to go ahead with setting up the service for you. If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

A higher standard of documentation is needed for Medical Records online registration. You will need two forms of documentation, one of which must contain a photo.

Acceptable documents include passports, photo driving licences and bank statements, but not bills (see website for full list).

Online login details will be provided when the surgery process has been completed which will then need to be collected direct from the surgery by the patient only.

This process can take up to eight weeks to ensure your medical records are processed correctly, (we reserve the right to request an extension if necessary and we reserve the right to refuse you access if we have not received your medical records from your previous surgery).

**Declaration (please delete response as appropriate):**

|  |  |
| --- | --- |
| 1. I agree to my GP practice giving me access to my record online.
 | YES / NO |
| 1. I have read and understood the information leaflet about access to GP medical records provided by the practice.
 | YES / NO |
| 1. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.
 | YES / NO |
| 1. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.
 | YES / NO |
| 1. I agree that it is my responsibility to keep secure my username and passwords. If I think these have been shared inappropriately I will reset them using the instructions supplied.
 | YES / NO |
| 1. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.
 | YES / NO |
| 1. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. *Please note, this does not affect your rights of Subject Access under the Data Protection Act.*
 | YES / NO |
| 1. I will be responsible for the security of the information that I see or download/print.
 | YES/NO |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | YES/NO |

**Other considerations**

|  |
| --- |
| The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.  |
| 1. If I notice any inaccuracies with my record, I will inform the practice manager as soon as possible of any errors or omissions.
 | YES/NO |
| 1. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.
 | YES / NO |
| 1. I understand that as before, I am responsible to contact the practice for any result and this includes any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.
 | YES / NO |

**Patient Details**

|  |  |
| --- | --- |
| Surname |  |
| First Name(s) |  |
| Date of Birth |  |
| NHS number (if known) |  |
| Address |  |
| Post Code |  |
| Telephone Number |  |
| Mobile Number |  |
| Email\* |  |

\*This email address is not shared with others and you agree that it can be used to send you confidential information about your account / the services used.

To be signed at reception by patient………………………………..……………..….

Date…………………………

 ***We will contact you when your medical records have been checked and a passphrase will be provided when this has been set up for you. Please remember to keep all your account details secure. If you think your account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service please speak to our Practice Manager.***

**For practice use only**

|  |
| --- |
| **RECEPTION DEPARTMENT** |
| **ID verified by (initials):**  | **Date:** | Vouching Vouching with information in record  |
|  ID provided  (give details) |
|  **ADMIN DEPARTMENT** |
| Patient NHS number: | Date passphrase printed: |
| **Level of record access enabled:** Detailed Coded Record |  |
| **Authorised by GP:** | **Date:** | **Authorised by Practice Manager:** | **Date:** |