Allied Medical Application form for online services

*There are two forms within this document – you only need to complete one.*

*Complete Form 1 for your own medical record and Form 2 to gain access to another patient’s record.*

Prior to seeking access 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 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.
* 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
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* ***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.

Form One: Online access form

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Surname | | Date of birth | | | | |
| First name | | | | | | |
| Address  Postcode | | | | | | |
| Email address | | | | | | |
| Telephone number | | | Mobile number | | | |
| To access my medical record online I understand and agree with each statement (tick) | | | | | | |
| 1. I will be responsible for the security of the information that I see or download and I have read the information on the next page | | | | | | □ |
| 2. If I choose to share my information with anyone else, this is at my own risk | | | | | | □ |
| 3. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | | | | | | □ |
| 4. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | | | | | | □ |
| 5. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. | | | | | | □ |
| Signature Date | | | | | |  |
| **For practice use only** | | | | | |  |
| Patient NHS number | | | | | |  |
| Identity verified by (initials)  Date | | | | Practice computer ID number | | |
| Documentary evidence provided | Method used | | | Vouching □  Vouching with information in record □ Photo ID and proof of residence □ | | |
| Authorised by | | | | |  | |
| Date access created | | | | | Date | |
| Date patient informed – or message added to clinical notes due to SMS message | | | | | | |
| Reason for refusal if record access is refused after clinical assurance. | | | | Assured by (initials) | | |

**Form Two: Consent to proxy access to GP online services**

***Note: If the patient does not have capacity to consent to grant proxy access and proxy access is considered by the practice to be in the patient’s best interest Section A may be omitted.***

***For parents wishing to gain access to their child’s medical records child consent is not required under the age of 12 years of age. Once the child reaches 12 years of age parental access will be automatically removed and will have to be reapplied for with their child’s consent. At 16 years of age access will once again be automatically removed.***

**Section A:**

I,………………………………………………….. (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 B

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 B:**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Accessing the medical record for (name of patient) | 🞏 |

**Section C:**

I/we…………………………………………………………………………….. (names of representatives) wish to have online access to the services ticked in the box above in section B

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:

|  |  |
| --- | --- |
| 1. I/we have read and understood the information leaflet provided by the practice and agree that I will treat the patient information as confidential | 🞏 |
| 1. I/we will be responsible for the security of the information that I/we see or download | 🞏 |
| 1. 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 | 🞏 |
| 1. 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 |

**Section D:**

**The patient**

(This is the person whose records are being accessed)

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

**The representatives**

(These are the people seeking proxy access to the patient’s online records, appointments or repeat prescription.)

|  |  |
| --- | --- |
| Surname | Surname |
| First name | First name |
| Date of birth | Date of birth |
| Address  Postcode | Address (tick if both same address 🞏)  Postcode |
| Email | Email |
| Telephone | Telephone |
| Mobile | Mobile |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| The patient’s NHS number | | The patient’s practice computer ID number | |
| Identity verified by  (initials) | Date | Method of verification  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | |
| Proxy access authorised by | | | Date |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled    Prospective 🞏  Retrospective 🞏  All 🞏  Limited parts 🞏  Contractual minimum 🞏 | | Notes / comments on proxy access | |