**Patient Consent Forms**

**Application for online access to my medical record**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | | |
| **First Name** |  | | |
| **Date of Birth** |  | | |
| **Address** |  | | |
| **Postcode** |  | | |
| **Email address** |  | | |
| **Home telephone Number** |  | **Mobile telephone Number** |  |

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

Current Request

|  |  |  |
| --- | --- | --- |
| Booking appointments | 🞏 | 🞏 |
| Requesting repeat prescriptions | 🞏 | 🞏 |
| Access to my medical record | 🞏 | 🞏 |

**I wish to access my medical record online and understand and agree with each statement (tick)**

|  |  |  |
| --- | --- | --- |
| I have read and understood the information leaflet provided by the practice | | 🞏 |
| I will be responsible for the security of the information that I see or download | | 🞏 |
| If I choose to share my information with anyone else, including my username and password, this is at my own risk | | 🞏 |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | | 🞏 |
| 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**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EMIS No. | |  | | |
| Identity verified by (initials) | Date | **Method**  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | | |
| Authorised by | | | | Date |
| Date account created: | | | | |
| Date passphrase sent: | | | | |
| Level of record access enabled  Contractual minimum 🞏  Other……………………. ……… | | | Notes / explanation | |

**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 1 of this form may be omitted.

**Section 1**

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 2.

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 2**

|  |  |
| --- | --- |
| 1. Online appointments booking | 🞏 |
| 1. Online prescription management | 🞏 |
| 1. Limited access to parts of the medical record for (name of patient) | 🞏 |

**Section 3**

I/we…………………………………………………………………………….. (Names of representatives) wish to have online access to the services ticked in the box above in section 2

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 | |

**The patient**

(This is the person whose records are being accessed)

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | | |
| First Name |  | | |
| Date of Birth |  | | |
| Address |  | | |
| Postcode |  | | |
| Email address |  | | |
| Home telephone Number |  | Mobile telephone 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**

|  |  |  |  |
| --- | --- | --- | --- |
| EMIS 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    Contractual minimum √  Other…………………… | | Notes / comments on proxy access | |