

Application for Online Access to Medical Records

www.nhs.uk/patientonline																				
	PLEASE READ FORM CAREFULLY and use BLOCK CAPITALS throughout																			
	SECTION A. MUST BE COMPLETED FOR ALL REQUESTS																			
ils	Please use one form per patient																			
eta	Surname						Age													
ıt D	First Name(s)												ate of Birth							
Patient Details	Home Address																			
			Post								ode									
A.	Email address																			
	Mobile									Home	no.									
	By giving your mobile	and/o	r ema	il you are	con	senting	to be	cont	tacted	by SM	S and	or er	nail whi	ch m	ay in	clude	medio	cal info	rmat	tion.
IJN.	1) BASIC ACCESS - Booking appointments, requesting repeat medication, view Summary Care Record, update address and contact details																			
Tick only ONE		cess can usually be given to you the same day. Please provide two valid forms of ation, one must be photo ID.																		
Tick (ANCED ACCESS - All of the Basic Access rights, plus: d Coded Record, i.e. allergies, medication, immunisations, results, procedure codes																		
'B	Please provide two valid forms of identification, one must be photo ID. You will need to return to the surgery in 7 working days to pick up login information.																			
٦	I wish to access my medical record online and understand and agree with the statement below:																			
C. Declaration	I confirm I have read the information leaflet provided by the surgery and agree to be responsible for the security of the information that I see or download. I understand that if I choose to share my information with anyone else, this is at my own risk. I understand that I should contact the practice as soon as possible if I suspect my account has been accessed without my permission or unlawfully. I understand I will contact the practice should I see information that is not about me or is incorrect.																			
0	Patient Signa	ature									D	ate								



If you are only requesting access to your own medical records you do not need to complete any further sections of this form.

Please see over for proxy/representative access.

This continue is to be completed as appropriate if a representative wishes to																			
This section is to be completed as appropriate, if a representative wishes to have proxy record access to the patient named in Section A overleaf.																			
have proxy record access to the patient named in Section A overleaf.																			
		The patient named in SECTION A, wishes the proxy/representative named below to have access to the following online services:																	
. Proxy / Representative Access	-		low a				king	Y	es/	No			Allow medication	equestin	g Yes	/ No			
		Allow	eting (questi	ionna	aires	Y	es/	No		Al	low viewing of summ	d Yes	/ No					
		Allow viewing	of de	tailec	code	ed re	cord	Y	es/	No			s *Yes	/ No					
		*If you want to grant temporary access only to your records, state the date you wish it to end													M M Y	Y			
		Preferred con	tact m	etho	d Ho	me p	ohone	e / m	obile	/ let	tter /	text r	message / no commu	ınication					
		Proxy / Representative Information Surname First name(s)																	
	ט מ	Surnan																	
	3	Phone n	0.									[Date of birth Date of birth	ММ	YY	Y			
	-	Home Address Post code																	
	אוואפ	Proxy/Represer patient in SECT				p to	the	Pa	rent /	/ Gua	ardiaı	n / C	arer / Other (specify)	:					
	3 =	The proxy/repr	esenta	ative i	must a	also	be re	egist	ered	to us	se on	line	services:		Tic	k if			
	ט מ							•						ered for	Attac	ched			
	2	SystmOnline, the proxy/representative must complete a separate online registration form														7			
	ש	(Section A-C) and attach it to this form.														with			
	/	 If the proxy/representative IS NOT a patient at this practice, the proxy/representative will be issued with a SystmOnline account user name and passphrase to allow access. 														VVICII			
	3	DISCLAIMER																	
	.	If patient in Section A is aged 11 or over, they must sign this disclaimer below. Please be aware that																	
	נ	 from the patient's 16th Birthday, all proxy access will be automatically revoked. If patient in Section A is aged under 11, we do not require their signature, only the representative. 																	
		 If patient in Section A is unable to sign themselves, please sign and print your name below⁶. 																	
		The patient named in SECTION A, consents to the above named person having proxy access to my medical records. I understand that I can change my mind about this at any time and if I wish to do so must														uot			
		contact the surgery and tell them the reason.																	
	-	PATIENT Sign	nature	requ	ired fo	or ag	ges o	ver '	11 ye	ars				Date					
	•	OR ^ℓ Si	gnatur	e of p	ersor	n rep	rese	nting	g pat	ient									
		OR *Signature of person representing patient Print name if representative of the patient Date												Date					
									•										
F	0	R PRACTICE	US	E OI	NLY														
L		Patient NHS Number								<u> </u>			Photo ID and proo	nce					
		Identity verified by							Da	ite			Vouching with informa						
		(initials) Basic (appointments/medication/ques								Vouching									
	Le	NAL OF PATIENT							tionnaires/SCR) \square sestionnaires/SCR/detailed-coded) \square^*										
		access granted	Detailed						Date										
		PROXY ONLY R	elations	ship to	Patient														

Patient consent (written)

Parental responsibility

SCR □ Detailed Coded □

Authorised by (admin)

Patient lacks capacity (patient's best interests)

Patient lacks capacity (court

Patient consent (verbal) \square

order) ☐ Patient lacks capacity (power of attorney) ☐

Appointments \square Medication \square Questionnaires \square

Basis for granting

PROXY ONLY

access

Access Granted NOT GRANTED □

Date account created & passphrase sent