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**Consent for Online Access to Appointment System/Repeat Medications/Medical Records**

**Parents Form**

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.

DECLARATION

**Please Delete Response as Appropriate:**

|  |  |  |
| --- | --- | --- |
| 1 | I agree that the GP practice will give me access to the records of the person i care, online. | YES / NO |
| 2 | I have read and understood the information leaflet about access to GP medical records. | YES / NO |
| 3 | 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 If not, access may be withdrawn.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 |
| 4 | If I see information which does not relate to the person i care for, I will immediately log out and report the matter to the practice as soon as possible. | YES / NO |
| 5 | I agree that it is my responsibility to keep the username and passwords secure. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record. | YES / NO |
| 6 | I agree that the details below may be used to contact me and/or the person i care for, about how useful I find the service and whether it could be improved. | YES / NO |
| 7 | I understand that online access is granted at the discretion of the practice, taking into account the best interests of the patient. 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 |

**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.

|  |  |  |
| --- | --- | --- |
| 8 | If I notice any inaccuracies with these records, I will inform the practice manager as soon as possible of any errors or omissions. | YES/NO |
| 9 | I understand that I may see information on these records that I was unaware of/have forgotten about that could cause distress. | YES / NO |
| 10 | I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to make contact. This could be while the surgery is closed and there is no one available to discuss them with me. | YES / NO |

**Patients Details:**

|  |  |
| --- | --- |
| Surname |  |
| First Name(s) |  |
| Date of Birth |  |
| Address |  |
| Post Code |  |
| Telephone Number |  |
| Mobile Number |  |

**Carers Details:**

|  |  |
| --- | --- |
| Relationship to Patient |  |
| Surname |  |
| First Name(s) |  |
| Date of Birth |  |
| Address |  |
| Post Code |  |
| Telephone Number |  |
| Mobile Number |  |

|  |  |
| --- | --- |
| Has the Patient Given Authority for the Carer to Access These Records? | Yes/No |
| Is There Written Consent From the Patient? If so, Please Attach | Yes/No |
| Or Please Specify Other Authority e.g. Lasting Power of Attorney | Yes/No |

To be Signed at Reception by the Carer: …………………………………… Date: …………….…….

***Please Retain This Copy of This Form for Your Information***

***We will contact you with your passphrase 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:***

|  |  |  |  |
| --- | --- | --- | --- |
| ID Checked Documents? | Yes/No | Initials of Staff Member: | Date: |
| GP Authorised? | Yes/No | Initials of Staff Member: | Date: |
| Account Created? | Yes/No | Initials of Staff Member: | Date: |
| Passphrase Sent? | Yes/No | Initials of Staff Member: | Date: |