

CEDAR BROOK PRACTICE

APPLICATION FOR ONLINE PATIENT ACCESS TO MEDICAL RECORDS

You can now view your GP medical record online to look at medication, allergies and problems.
You can also request your prescription and book your appointment on line by Patient Access.

Children under the age of 11 can be registered for this service by a parent/guardian, proof of ID i.e. birth certificate/ passport will be required for the child.

Children age 11 – 15 years will be required to complete the patient Access form and if permitted give proxy Access to the parent/guardian by completing the consent for proxy patient access form attached. In all cases the patient must sign the form at the practice in person.

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 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 circle response as appropriate):

I agree to my GP practice giving me access to my record online.	YES	NO
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 If not access may be withdrawn.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
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
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. I am also responsible for keeping safe any information I may print from the record.	YES	NO
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
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

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
I understand that I may see information on my record that I was unaware of / have forgotten about, that could cause distress.	YES	NO
I understand that as before, I will be informed by the practice of any test results which require further action, when I contact the practice for the results. 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	
Telephone number	
Mobile number	
Email* Please write clearly	
Would you like your log in details to be sent to your email address	Please circle or tick yes or no below YES NO
Name and address of pharmacy electronic prescriptions can be sent to	

*If this address is shared with others please consider whether you agree that it can be used to send you confidential information about your account / the services used.

THIS FORM MUST NOW BE TAKEN INTO THE PRACTICE AND SIGNED IN FRONT OF THE RECEPTIONIST – YOU WILL NEED TO PROVIDE PHOTO IDENTIFICATION WHICH INCORPORATES YOUR SIGNATURE TOGETHER WITH PROOF OF YOUR ADDRESS (IDEALLY A UTILITY BILL DATED WITHIN THE LAST 3 MONTHS)

To be signed at reception by patient

Date

<p>Children age 0 – 10 years To be signed by parent/guardian.....</p> <p>Name of parent/guardian.....</p> <p>Relationship to patient.....</p>
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Children age 11 – 15 years

To be signed by patient.....

If parent/guardian to be permitted proxy Access, please complete the attached Consent for Proxy patient access form.

Carers for patients who cannot use the internet

Please complete the consent for proxy patient access form.

We will contact you when this has been set up. 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 ring us on 020 8845 7100.

For practice use only

Photo ID/signature and proof of address checked and attached to this form

YES NO

Receptionist Name

Date

GP authorised YES NO Name of GP

Date

Account enabled by:Date.....

Code 912P

Patient informed: YES NO Date