**Homestead Medical Centre**

**Application for Online Access to Services**

### Section 1 – Your Details

|  |  |
| --- | --- |
| **Surname** |  |
| **First Name** |  |
| **Date of Birth** |  |
| **Address** | **Postcode: WF** |
| **Email Address** |  |
| **Mobile Phone** |  |
| **Telephone No** |  |

|  |  |
| --- | --- |
| I am aged 16 years or above and I am requesting access to my own online services |  |
| I am aged 12 – 15 and I am requesting access to my own online services ***(GP Consent Required)*** |  |

### Section 2 – Terms of Agreement

**I wish to access my online services and understand and agree with each statement below;**

*(Please tick)*

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice about online access |  |
| I will be responsible for the security of my login details as well as any of the information that I see or download |  |
| If I choose to share my information with any else, this is at my own risk |  |
| I understand that abusing the online services offered will result in the online service being removed |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed 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. |  |
| I consent to the practice using my email address and phone number for reminders and communication from the practice |  |

### Section 3 – Communication

**Please confirm how you would like to receive your login details;**

|  |  |
| --- | --- |
| I wish to have my login details sent to the EMAIL address provided above |  |
| I wish to have my login details sent by SMS to the mobile number provided above |  |

*You may receive a verification email/SMS asking you to confirm your identity before your login details can be sent*

### Section 4 – application

**Please confirm which of the following services you would like access to:**

|  |  |
| --- | --- |
| Online access to book and cancel appointments |  |
| Online access to order repeat prescriptions |  |
| Online access to my summary care record |  |
| Online Access to all READ coded entries can be granted after your first login – please apply using your online account. | |
| Online access to my FULL medical record - Not yet available to patients | |

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

|  |  |
| --- | --- |
| 1. I have read and understood the information on page 3 of this form |  |
| 1. I will be responsible for the security of the information that I see or download |  |
| 1. If I choose to share my information with anyone else, this is at my own risk |  |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| 1. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible |  |

***Section 5 - Consent***

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**Please return this form to Reception with some form of photographic evidence.**

**The practice will be in contact to confirm your access details.**

**Important Information – Please read before returning this form**

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.

**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.**

If you can’t do this for some reason, 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. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.**

## Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

|  |
| --- |
| **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. |
| **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. |

**PRACTICE USE ONLY**

|  |  |  |
| --- | --- | --- |
| **RECEPTION STAFF USE** | | |
| **Patient NHS No:** |  | **Method of Identity Verification;**  Documentation (copy attached)  Vouching with information from record  Photo ID  Proof of residence  Vouching by GP/Management:-  Name of person vouching / verifier |
| **Date form handed in & verified:** |  |
| **Staff Name:** |  |
| **THIS FORM SHOULD BE SENT TO ZOE / NOREEN** | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DATA INPUT STAFF USE** | | | | | | | |
| **Request Sent to (GP):** |  | | | | **Date:** |  | |
| **Account created by:** |  | | | | **Date:** |  | |
| **SMS/Email Verification:** | Verified: | Sent on:  / / | | | | | |
| **Username sent:** | SMS/EMAIL | / / | **Password sent:** | SMS/EMAIL | | | / / |
| Notes: | | | | | | | |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **GP USE** | | | |
| **GP Name:** |  | | |
| **I am allowing the user access to the following services;** | | | **I do not feel the patient is competent in managing their own health care** |
| Online appointment management | |  |
| Online prescription management | |  |
| Online access to summary medical record | |  |
| Online access to READ coded entries | |  |  |
| Online access to FULL medical record | |  |  |
| *I have assessed the applicant for Gillick Competence in managing their own health care and have recorded the appropriate code in the patients’ record.*  Signature of GP: Date: | | | |