Application for Online Access to Services for Another Patient

This form should be completed **in addition** to the “Application for Online Access to Services” if you require access to another patients online services.

### Section 1- Patients Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients Name** |  | **Patients** **Date of Birth** |  |
| **Patients Address** |  |
|  **Postcode:** |

### Section 2 – Application Type

|  |  |
| --- | --- |
| I am requesting access to the online services of a child aged 11 and under for whom I have parental responsibility | [ ]  |
| I am requesting access to the online services of a child aged 12 – 15 for whom I have parental responsibility because; |
| *The patient is lacking competency in managing their own healthcare* | [ ]  |
| *The patient is competent and has given consent for my access* | [ ]  |
| I am requesting access to the online services of a patient aged 16 and over who lacks the competency to manage their own healthcare *(GP assessment or Legal Documentation required)* | [ ]  |
| I am requesting access to the online services of a patient and I have consent from the patient. | [ ]  |

### Section 3 – Terms of Agreement

**I understand and agree with each statement below with regards to the patient’s online information;** *(Please tick)*

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice about online access and will treat the patients information as confidential | [ ]  |
| I will be responsible for the security of any of the information that I see or download | [ ]  |
| I will contact the practice as soon as possible if I suspect that the account has been accessed without my agreement.  | [ ]  |
| If I see information in the record that is not about the patient or is inaccurate, I will contact the practice as soon as possible. I will treat this information as strictly confidential. | [ ]  |

### Section 4 – Consent

**Applicants Signature: Date:**

|  |  |
| --- | --- |
| I understand the risks of allowing the user access to the services ticked and I understand that I reserve the right to remove this access at any time.  | **I am allowing the user proxy access to the following services;** |
| Online appointment management | [ ]  |
| Online prescription management | [ ]  |
| Online access to my summary medical record | [ ]  |
| Online access to my READ coded record | [ ]  |
| Online access to my FULL medical record | Not available yet |

**Patient Consent**(if appropriate)**;**

**Patients Signature: Date:**

**PRACTICE USE ONLY**

|  |
| --- |
| **RECEPTION STAFF USE** |
| **Patient NHS No:** |  | **Method of Identity Verification;**Documentation (copy attached)Vouching with information from both recordsPhoto IDProof of residenceVouching 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 applicant should be allowed access to the patients’ online services.** |
| 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 her own health care and have recorded the appropriate code in the patient’s record.*Signature of GP: Date: \_\_\_\_\_\_  |