Application for Online Access to Services

Section 1 – Your Details

Name		**Date of Birth**	
Address	**Postcode:**		
Email Address			
Mobile Phone			

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 - Consent

Your Signature: _____ **Date:** _____

Please return this form to Reception. The practice will be in contact to confirm your access details.

If you require access to another patients records please complete the additional form "Application for Online Access to Services for Another Patient"

PRACTICE USE ONLY

RECEPTION STAFF USE		
Patient NHS No:		**Method of Identity Verification;** ☐ Documentation (copy attached) ☐ Vouching with information from record ☐ Vouching by GP/Management:-
Date:		
Staff Name:		
THIS FORM SHOULD BE SENT TO ADMINISTRATION		(Name_____)

ADMIN 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	☐	
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:_____		
GP NOTE: Please ensure the following codes are added to the patients' records as appropriate and indicate below the code you have used; *Gillick competent for consent [XaKIJ]'* *'Not Gillick competent for consent [XaXLv]'*		
GP's please return this form to Administration when completed.		

If you require access to another patients records please complete the additional form "Application for Online Access to Services for Another Patient"