# 

**SQUIRES LANE MEDICAL PRACTICE**

**Dr E Barthes-Wilson & Dr G Thawani**

**Online Access Request for Adults and children who are older than 13 years old**

|  |  |
| --- | --- |
| Surname | Date of birth: |
| First name | |
| Address  Postcode: | |
| Email address: | |
| Telephone number: | Mobile number: |

If aged 13, 14 or 15years: are patient AND parent present at time of application?

Patient alone Patient and parent present Parent alone 

PARENTAL CONSENT OBTAINED YES / NO *(circle as appropriate)*

Parent’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I (**patient/parent)** *(delete as appropriate)* wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my detailed coded records; medications and allergies |  |
| 4. Hospital letters |  |

I wish to access **my/my child’s** *(delete as appropriate)* medical record online and understand and agree with each statement (tick).

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 2. I will be responsible for the security of the information that I see or download |  |
| 3. If I choose to share my information with anyone else, this is at my own risk |  |
| 4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 6. At the age of 16 years, any online access to a third party including my parents will automatically cease and I will need to reapply for online access |  |
|  |  |

Signature of patient/parent:

*(delete as appropriate)*

Date:

Name of patient/parent:

*(delete as appropriate)*

# For practice use only - IF PATIENT IS AGED 13, 14 OR 15YEARS, PLEASE PASS THIS REQUEST TO THE DOCTOR FOR CONSIDERATION – DO NOT ISSUE ONLINE ACCESS UNTIL THE DOCTOR HAS APPROVED THE REQUEST

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by (initials) | Date | Method: Vouching with information in record   Photo ID (Patient ID/Parent ID)   *(delete as appropriate)* | |
| Authorised by | | | Date |
| Date account created | | | |