**REQUEST FOR ONLINE ACCESS TO MEDICAL RECORDS – (**please refer to the notes overleaf**)**

1. **About the Patient whose records you want to access on-line**

**ALL SECTIONS ON THE LEFT MUST BE COMPLETED**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Firstname:** | | | | | | | | | | | | **Surname:** | | | | | | | | | | | | | **Date of Birth:** | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |
| **First line of address:** | | | | | | | | | | | | | | | | | | | | | | | | | **Postcode:** | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| **Home Telephone:** | | | | | | | | | | | | | | | | **Mobile Telephone:** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Email address** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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Preferred method of  
communication: **SMS EMAIL NONE Signature:**

1. **I wish to access my medical record on-line   
   and understand and agree with each statement** Tick all boxes

|  |  |  |
| --- | --- | --- |
| a) | I have read and understood the NHS ‘What you need to know about your GP online record’ leaflet (link on Greenwood Surgery Website – online services) |  |
| b) | I will be responsible for the security of the information that I see or download |  |
| c) | If I choose to share my information with anyone else, this is at my own risk |  |
| d) | I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |  |
| e) | If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |

1. **About You** Tick the relevant box (ONE Only)

|  |  |  |
| --- | --- | --- |
| a) | I am aged 16\* years or above and I am requesting on-line access to my own medical records |  |
| b) | I am aged 12-15 years and I am requesting on-line access to my own medical records |  |
| c) | I am aged 12-15 years and I am requesting the **removal** of on-line access by my parent/carer to my medical records |  |
| d) | I am the parent/carer of a child aged less than 12 years and I am requesting on-line access to their medical records |  |
| e) | I am the parent/carer of a child aged 12 to 15 years and I am requesting on-line access to their medical records |  |

\* Patients who will reach the age of 16 within the next 4 weeks should select this box

1. **Signatures**

Patient/Child signature: Date signed:

Your parent/carers signature: Date signed:

**For Greenwood Surgery Administration Use (Reception)**

|  |  |  |
| --- | --- | --- |
|  | **Initials** | **Date** |
| Request received |  |  |
| Request reviewed with GP |  |  |
| Outcome code |  |  |
| Outcome actioned |  |  |
| ID Shown |  |  |

**CONSENT TO DISCLOSE CONFIDENTIAL MEDICAL INFORMATION**

Name: Date of Birth:

Address:

I hereby consent to the disclosure of my private medical information to:

Name: Date of Birth:

Relationship: Tel. No:

Address:

Please circle the statement(s) that are applicable:

*Full and open ended disclosure of any matter related to my medical record* **YES / NO**

*Full disclosure of any matter related to my medical record for the period* **YES / NO**

( *From* ): ( *To* ):

*Limited disclosure of the following aspects of my medical record:*

* *Test Results* **YES / NO**
* *Prescription queries* **YES / NO**
* *Appointment queries* **YES / NO**
* *Referral queries* **YES / NO**
* *Any other matter related to my medical record, please state:*

**YES / NO**

**I am aware that this consent may be revoked by me at any time.**

Signature: Date:

Witnessed by (not the individual for whom consent is being granted):

Name: Signature:

Address:

**If you need assistance in completing this form please ask the Receptionist.**