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.**

 **PRACTICE USE ONLY**

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

|  |
| --- |
| **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 returning this form to Administration when completed.** |