**Horne Street Surgery**

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 |  |

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

**Patients Signature: Date:**

**PRACTICE USE ONLY**

|  |  |  |
| --- | --- | --- |
| **RECEPTION STAFF USE** | | |
| **Patient NHS No:** |  | **Method of Identity Verification;**  Documentation including proof of relationship (copy attached)  Vouching with information from both records  Vouching 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 applicant access to the following services for the patient named in this application;** | | | **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 | |  |
| *Notes:*  Signature of GP: Date: | | | |
| **GP NOTE: Please ensure you have documented any notes in the patients record** | | | |
| **GP’s please return this form to Administration when completed.** | | | |