**PATIENT Details**

|  |  |
| --- | --- |
| Surname: | Date of birth: |
| First name: | Age: |
| Address:  |
| Postcode: | Telephone Number: |

Put a tick in the boxes below 

|  |  |  |
| --- | --- | --- |
| **Help button** | I want my GP practice to let other people help me manage my health  |  |
| Person sat thinking on question mark | I know that I can change my mind about this at any time |  |
| thumbs up sign | I understand the risks of allowing someone else to have access to my health records |  |
| Calendar | I want help to book my appointments |  |
| Medicines | I want help to order my medicines |  |
| Contact icons | They can update my contact details for me |  |
| person on a computer | They can have secure online access to all of my electronic GP records  |  |
| **Signature:** |
| **Date:** |

|  |
| --- |
| This box will be used if it is decided that you are unable to give your consent to someone having access to your records. You do not need to write anything here, the person making that decision will use it to record the reasons why:  |
|  |

### PROXY DETAILS NUMBER 1 – these are the people that you would like to help you

|  |  |
| --- | --- |
| **Full Name:** |  |
| **DOB:** |  |
| **Address:** |  |
| **Tel. No:** |  |
| **Email address:** |  |
|  | **Are you already registered at Hillview Family Practice for GP online services?*** **Yes**
* **No**
 |
| **Relationship to patient:** |  |
| * I will be responsible for the security of the information that I see or download
* If I choose to share information with anyone else, this is at my own risk
* I will contact the practice as soon as possible if I suspect that this account has been accessed by someone without my agreement
* If I see information in the record that is not about the patient or inaccurate, I will contact the practice as soon as possible
 |
| **Signature:** |  |
| **Date:** |  |

###  PROXY DETAILS NUMBER 2 – these are the people that you would like to help you

|  |  |
| --- | --- |
| **Full Name:** |  |
| **DOB:** |  |
| **Address:** |  |
| **Tel. No:** |  |
| **Email address:** |  |
|  | **Are you already registered at Hillview Family Prcatice for GP online services?*** **Yes**
* **No**
 |
| **Relationship to patient:** |  |
| * I will be responsible for the security of the information that I see or download
* If I choose to share information with anyone else, this is at my own risk
* I will contact the practice as soon as possible if I suspect that this account has been accessed by someone without my agreement
* If I see information in the record that is not about the patient or inaccurate, I will contact the practice as soon as possible
 |
| **Signature:** |  |
| **Date:** |  |

***For Reception use: ID FOR ALL PARTIES REQUIRED***

|  |  |  |
| --- | --- | --- |
| **Patient NHS number:** | **PATIENT SYSTEM ID number:** | **GP:** |
| **Identity verified by****(FULL NAME):****Sign: Date:** | **Patient ID: Tick all that apply:****Personal vouching 🞏****Vouching with information in record 🞏Birth Certificate/Passport/Photo Driving Licence 🞏****Proof of residence 🞏**  |
| **Identity verified by****(FULL NAME):****Sign: Date:** | **PROXY 1: Tick all that apply:** **Personal vouching 🞏****Vouching with information in record 🞏****Birth Certificate/Passport/Photo Driving Licence 🞏** **Proof of residence 🞏** |
| **Identity verified by****(FULL NAME):****Sign: Date:** | **PROXY 2: Tick all that apply:** **Personal vouching 🞏****Vouching with information in record 🞏****Birth Certificate/Passport/Photo Driving Licence 🞏** **Proof of residence 🞏** |

**Information for those with PROXY access**

* Remind proxy that the patient’s GP *might* need to discuss this application further with either the patient, or the proxy, or both
* Advise that the practice will contact the proxy to collect registration details if proxy is not already registered for online access, or the proxy might be emailed the details directly
* Otherwise, proxy access will be automatically activated once GP has approved application