**PATIENT Details**

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

**Fill in this section if you want access to your own online record** (Your GP **may** want to discuss this form with you)

Put a tick in the boxes below 

|  |  |  |
| --- | --- | --- |
| **Help button** | I would like to have my own access |  |
| Person sat thinking on question mark | I know that I can change my mind about this at any time |  |
| Calendar | I want to book my own appointments |  |
| Medicines | I want to order my own medicines |  |
| Contact icons | I want to be able to update my own contact details |  |
| person on a computer | I want secure online access to all of my electronic GP records |  |
| * 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 me, or inaccurate, I will contact the practice as soon as possible | | |
| **Signature:** | | |
| **Date:** | | |

**Fill in this section if you want to give someone else access (you can have your own access as well as other people)**

|  |  |  |
| --- | --- | --- |
| **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 informed consent to proxy access. 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 child, 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 Practice for  GP online services?**   * **Yes** * **No** |
| **Relationship to patient:** |  |
| As a proxy I understand that 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 child, 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 🞏**  **Does this proxy have PARENTAL RESPONSIBILITY? 🞏** | | |
| **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 🞏**  **Does this proxy have PARENTAL RESPONSIBILITY? 🞏** | | |

**Parental responsibility applies if PROXY is:**

* The birth mother
* The birth father and married to the mother at the time of child’s birth or subsequently
* The birth father and *not* married to the mother, but the child
  + was born after 01/12/2003 *and*
  + father’s name is on the birth certificate
* An adoptive parent
* The child’s legal guardian
* Has court-appointed parental responsibility