# Application for Online Access to Services

The Grange, Greenview & Kinsley Medical Centres

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.**

***If you require access to another patients online services please complete the additional form***

***“Application for Online Access to Services for Another Patient”***

 **PRACTICE USE ONLY**

|  |
| --- |
| **RECEPTION STAFF USE** |
| **Patient NHS No:** |  | **Method of Identity Verification;** Documentation (copy attached) Vouching with information from record 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 Verified:****Verification:**  | Sent onDate: |
| **Username****Sent: Print /SMS /Email Date: / /**  | PasswordSent**: Print /SMS /Email Date: / /**  |
| Notes: |
| **GP USE** |
| **GP Name:** |
| **I am allowing the user access to the following services;** |  |
| **Online appointment management** | I do not feel the patient is competent in managing their own health care. |
| **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 patient’s record.Signature of GP……………………………………………………..Date…………………………………… |
| **GP NOTE: Please ensure the following codes are added to the patient’s records as appropriate and indicate below the code you have used:**Gillick competent for consent (XaKIJ) Not Gillick competent for consent (XaXLv) |
| **Please return this form to Administration when completed.** |

***If you require access to another patients records please complete the additional form***

***“Application for Online Access to Services for Another Patient”***

#