LONG BENNINGTON MEDICAL CENTRE

ONLINE ACCESS TO HEALTH RECORDS REQUEST

In accordance with the UK General Data Protection Regulation (UK GDPR)

Guidance notes – please read before completing this form:

If a child aged 13 or over has 'sufficient understanding and intelligence to enable him/her to understand fully what is proposed' (known as Gillick Competence), then she/he will be competent to give consent for him/herself but may wish a parent to countersign as well.

- Patients requiring access to their own record (Sections 1, 2 and 7)
- Proxy access to health records where patient has capacity (Sections 1, 3, 5, 6 and 7)
- Proxy access to health records where patient does not have capacity (Sections 1, 4, 5, 6 and 7)
- Parents requiring access to their child's (age 13-17) record (Sections 1, 3, 5, 6 and 7)

Proof of identity

Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up.

Please speak to reception if you are unable to provide this.

Section 1: Patient details

Surname		**Maiden name**	
Forename		**Title**	
Date of birth		**Address:**	
Telephone number		**Postcode:**	
NHS number (if known)		**Hospital number (if known)**	

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Section 2: Record requested

I wish to have access to the following online services (please tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Access to my medical records	☐

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

I have read and understood the information leaflet provided by the organisation	☐
I will be responsible for the security of the information that I see or download	☐
If I chose to share my information with anyone else, this is at my own risk	☐
I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible	☐

Patient signature		**Date**	

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Section 3: Consent to proxy access to GP Online Services (if patient has capacity)

- I…… (name of patient), give permission to my GP practice to give the following person/people …… proxy access to the online services as indicated below in Section 5

- I reserve the right to reverse any decision I make in granting proxy access at any time
- I understand the risks of allowing someone else to have access to my health records
- I have read and understand the information leaflet provided by the organisation

Patient signature		**Date**	

I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	
Telephone		**Telephone**	
Mobile		**Mobile**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper)

Reason for access:

I have been asked to act by the patient	☐
I have full parental responsibility for the patient and the patient is under the age of 18 and has consented to my making this request or is incapable of understanding the request (delete as appropriate)	☐

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Section 4: Consent to proxy access to GP Online Services (if patient does not have capacity)

I/We wish to have access to the health records on **behalf of** the above-named patient

Surname		**Surname**	
First name		**First name**	
Date of birth		**Date of birth**	
Address		**Address**	
Postcode		**Postcode**	
Email		**Email**	
Telephone		**Telephone**	
Mobile		**Mobile**	

(If more than one person is to be given access then please list the above details for each additional person on a separate sheet of paper).

Reason for access:

I/We have been appointed by the Court to manage the patient's affairs and attach a certified copy of the court order appointing me to do so	☐
I am/We are acting *in loco parentis* and the patient is incapable of understanding the request	☐
I am/We are the deceased person's personal representative and attach confirmation of my/our appointment (grant of probate/letters of administration)	☐
I/We have written and witnessed consent from the deceased person's personal representative and attach Proof of Appointment	☐
I/We have a claim arising from the person's death (please state details below)	☐

Section 5: Proxy access online services available

I/We wish to have access to the following online services (please tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Access to my medical records	☐

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Section 6: Proxy declaration

I/We wish to access to the medical record online of the above patient and I/we understand and agree with each statement (tick)

I/We have read and understood the information leaflet provided by the organisation and agree that I/we will treat the patient information as confidential	☐
I/We will be responsible for the security of the information that I/we see or download	☐
I/We will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without my/our agreement	☐
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the organisation as soon as possible. I/we will treat any information which is not about the patient as being strictly confidential	☐

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to apply for access to the health records referred to above under the terms of the Data Protection Act 2018.

You are advised that the making of false or misleading statements in order to obtain personal information to which you are not entitled is a criminal offence which could lead to prosecution.

Applicant signature		**Date**	

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ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

- Signed and dated the form
- Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature
- Enclosed documentation to support your request (if applicable)

Incomplete applications will be returned; therefore please ensure you have the correct documentation before returning the form.

For office use only:

Identification verification must be verified through two forms of ID

- One of which must contain a photo e.g., passport, photo driving licence or bank statement

  Where this is not available, vouching by a member of staff or by confirmation of information in the records by one of the management team or a partner may be used

Request received		Request refused		
Reviewed by HCP		Request completed		
Comments				
Identification of	☐ Child (aged 13-17)	☐ Patient	☐ Applicant	
Identity verified by		Date		
Identity method	☐ Photo ID or proof of residence – Type ……. ☐ Photo ID or proof of residence – Type ……. ☐ Vouching – by whom …… ☐ Vouching with information in record – by whom ……			
Proxy access authorised by				
Proxy access coded in notes	☐ Yes	NHS/EMIS No:		
Date account created		Date password sent		
Level of access enabled	☐ All	☐Prospective	☐ Retrospective	☐ Limited parts
Notes for proxy access *(If any request is refused, discuss with the organisation's DPO before informing patient/applicant)*				