



Online Access to Full Clinical Record Patient Consent

You have requested to view your full GP medical record online.

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information about you (provided below) to set up the and operate the service.

The following form will take you through the things you need to think about. By signing the form you will be giving us your permission to activate this service for you. If you decide not to join, or wish to withdraw at any time, your treatment will not be affected in any way.

Declaration (please delete response as appropriate):

1. I agree to my GP practice giving me access to my medical record online.	YES / NO
2. I have read and understood the patient online access to medical records information leaflet 'It's your choice'.	YES / NO
3. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not access may be withdrawn.	YES / NO
4. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.	YES / NO
5. I agree that it is my responsibility to keep secure, my username and passwords. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.	YES / NO
6. I understand that online access is granted at the discretion of the practice, taking into account my best interests. I will be informed of any decision to withdraw the service. <i>Please note, this does not affect your rights of Subject Access under the Data Protection Act.</i>	YES / NO

Other considerations

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.	
7. If I notice any inaccuracies with my record, I will inform the reception manager or practice manager as soon as possible of any errors or omissions.	YES/NO
8. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.	YES / NO
9. I understand that as before, I will be informed directly, by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.	YES / NO

Patient Details

Surname	
First Name(s)	
Date of Birth	
NHS number (if known)	
Address	
Post Code	
Telephone Number	
Mobile Number	
Email*	

*If this address is shared with others please consider whether you agree that it can be used to send you confidential information about your account / the services used.

To be signed at reception by patient:

Date:

We will contact you when this facility has been activated. Please remember to keep all your account details secure. If you think your account details may have been shared with someone you should reset them straight away. If you have any queries or concerns about the service or wish to withdraw from the service please speak to the Reception Manager or Practice Manager.

For practice use only:

ID checked documents: Yes No Receptionist Name:

Date:

GP authorised: Yes No Name of GP:

Date:

Medical records activated by: Date:

Patient informed: Yes No Date:

Pass to scanning