# The Snaith & Rawcliffe Medical Group

**Application for Online Access for another Patient**

|  |  |
| --- | --- |
| **Surname** |  **Date of birth** |
| **First name** |
| **Address****Postcode** |
| **Email address** |
| **Telephone number** |  **Mobile number** |

**Application Type (please tick all that apply):**

|  |  |
| --- | --- |
| Requesting access to online services of a child aged 11 and under for whom I have parental responsibility  |  |
| Requesting access to online services of a child aged 12–15 for whom I have parental responsibility because: |  |
|  The patient is lacking competency in managing their own healthcare |  |
|  The patient is competent and has given consent for my access (**patient to sign below**) |  |
| I am requesting access to the online services of a patient and I have consent from the patient:- |  |
|  Please attach consent. |  |

**I wish to access my medical record online and understand and agree with each statement (tick)**

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by the practice |  |
| I will be responsible for the security of the information that I see or download |  |
| If I choose to share my information with anyone else, this is at my own risk |  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.  |  |
|  |  |

 **Applicants Signature**: **Date:**

 I understand the risks of allowing the user access **I am allowing the user proxy access to the**

 to the services ticked and I understand that I reserve **following services;**

 the right to remove this access at any time. \***Booking Appointments**

 \* **Requesting Repeat Prescriptions**

 **Patients Consent (Aged 12 -15) ;**

 **Patients Signature: Date:**

# For practice use only

|  |  |
| --- | --- |
| Patient NHS number | Practice computer ID number |
| Identity verified by (initials) | Date | MethodVouching Vouching with information in record Photo ID and proof of residence  |
| Authorised by | Date |