**Patient Online: Registration form Access to GP online services**

**PROXY ACCESS ONLY**

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Email Address |  |
| Telephone Number |  | Mobile Number |  |

I wish to have access for the following patients:-

Patient Names and Date of Birth …………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………….

Reason for access:-

Patient consent (verbal) – Patient lacks capacity (court order) –

Patient consent (written) – Patient lacks capacity (power of attorney) –

Parental Responsibility – Patients best interests –

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

|  |  |
| --- | --- |
| Booking / cancelling / amending appointments |  |
| Requesting repeat prescriptions |  |
| Accessing my summary medical record |  |
| I would like to receive communication by email |  |
| I would like to receive appointment reminders by text |  |

I wish to access my personal information online and understand and agree with each statement:-

|  |  |
| --- | --- |
| I have read and understand 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 |  |
| I will contact the practice 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 log out immediately and contact the practice as soon as possible |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Identity verified through (tick all that apply)** | **Vouching** **Photo ID** **Proof of residence**  | **Name of Verifier** | **Date** |
| **Name of person who authorised** |  | **Date** |
| **Date account created** |  |
| **Date passphrase sent** |  |

Please complete and return to the GP Receptionist who will forward the form to your Child Health Records Department.

Date:

Parent/Legal Guardian Name:

Relationship to Child/Children:

Address:

Name and address of GP: ST GEORGES MEDICAL PRACTICE, Yarm Road, Middleton St George DL21BY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Details** | **1st Child** | **2nd Child** | **3rd Child** | **4th Child** |
| **First Name of Child** |  |  |  |  |
| **Surname of Child** |  |  |  |  |
| **Date of Birth** |  |  |  |  |
| **Gender** |  |  |  |  |
| **NHS Number** |  |  |  |  |
| **Previous Nursery/School** |  |  |  |  |
| **Current School** |  |  |  |  |
| **Name & Contact Details of Previous GP** |  |  |  |  |

For use by GP Practice: Please return this form to Child Health Records Department via email:-

Cdda-tr.southdurhamchildhealth@nhs.net and HDFT.0-19darlington@nhs.net