**Online Access to Medical Records Request**

**For patients aged 16 and over only**

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

**Guidance notes – please read before completing this form:**

Before you complete this form, please read the “**Access to Online Services Patient Information’** leaflet provided to you by Reception, which explains the levels of information available and how to make an informed choice regarding online access to your record.

Please complete this form and return it to the practice, along with two forms of identification one of which must be photographic.

**Section 1: Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | **Former name** |  |
| **Forename** |  | **Title** |  |
| **Date of birth** |  | **Address:** |  |
| **Telephone number** |  | **Postcode:** |  |
| **NHS number (if known)** | **Hospital number (if known)** |
| **Email Address:** |  |

**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 retrospective electronic medical records | 🞏 |
| Access to my prospective electronic 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 understand that I will automatically see any new information (prospective records) that is added to my healthcare record. | 🞏 |
| 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 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** |  |

**For office use only:**

**Identification verification must be verified through 2 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 clinicians may be used.

If this is a proxy request, where patient has capacity, both patient and proxy should provide identification as above in person.

|  |  |
| --- | --- |
| **Request received** |  |
| **Patient identity verified by** |  | **Date** |  |
| **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 …………………… |
| **Request reviewed by** |  |
| **Request completed** |  | **Request refused** |  |
| **Level of access enabled** | □ All | □Prospective | □ Retrospective | □ Limited parts |
| **Date account created** |  | **Date password sent** |  |
| **Comments** |  |