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| **CROSS KEYS PRACTICE** High Street, Princes Risborough, Buckinghamshire, HP27 0AXTelephone : 01844 344488 |

**PATIENT ONLINE: REGISTRATION FORM FOR PROXY ACCESS TO GP ONLINE SERVICES**

|  |  |
| --- | --- |
| Patient Name (Please Print) |  |
| Patients Date of birth |  |
|  | **Proxy User information (Please Print)** |
| Proxy User Name  |  |
| Proxy User Date of Birth |  |
| Proxy User Email address |  |
| Proxy User Home number |  |
| Proxy User Mobile number |  |

**I WISH TO HAVE ACCESS TO THE FOLLOWING ONLINE SERVICES (TICK ALL THAT APPLY):**

 **PLEASE NOTE THAT UNDER 16’S WILL ONLY HAVE ACCESS TO MEDICATION, ALLERGIES & IMMUNISATIONS**

 **Access (please tick)**

|  |  |
| --- | --- |
| Accessing my medical record - Medication and allergies |  |
| Accessing my medical record - Test results and immunisations |  |
| Accessing my medical record - Problems, consultations and letters |  |

Available at this GP Practice from 1st April 2016

Existing patients will be able to see their medical record items entered on/after 1st April 2016. New patients will be able to see records from date of registration onwards. Please be aware that by setting up this agreement you are giving another person access to your medical information which may include personal information from your past.

***I WISH TO ACCESS MY MEDICAL RECORD ONLINE AND UNDERSTAND AND AGREE WITH EACH STATEMENT* (PLEASE TICK)**

|  |  |
| --- | --- |
| 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 be 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 immediately via Secure Messaging within my Patient Access account or I will contact the practice by telephone after 2pm |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of patient if over 11 and has capacity. |  | Date |  |
| Signature of Proxy user. |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through (tick all that apply) | Vouching □Vouching with information in record □Photo ID □Proof of residence □ |  Name of verifier  | Date |
| Name of person who authorised (if applicable) and date |  |
| Date account created |  | Date passphrase sent |  |

 **FOR PRACTICE USE ONLY**