WESTERN AVENUE MEDICAL CENTRE

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Consent for Online Access to Medical Records

This questionnaire goes through the main issues that you need to understand before you can access your medical record over the internet. It will raise questions that you may not have considered to help you to decide whether or not to access your record in this way.

To confirm your registration:
2 forms of documentation must be provided as evidence of your identity. One of these must contain your photo and the other, your address.

Please answer **all** of the questions, deleting the answer that does not apply. Please also use **black ink** as the form needs to be scanned onto your record.

Patient Name		
Patient Date of Birth (only patients 16+ are eligible for online access to medical records)		
Email Address (required)		
Home Phone Number		
Mobile Phone Number		
Are you completing this questionnaire for yourself?	YES	NO
If you answered NO then please state your name and relationship to the patient		
Are you registered for Patient Access allowing you to order repeat prescriptions, book appointments etc?	YES	NO
Are you happy to use a username and password to access your records?	YES	NO
You should not share your username and password. Do you agree to not share this information?	YES	NO
If you answered NO to the question above, please give your reason(s)		

When accessing your medical records online, there may be instances when you may read some information that could be shocking/upsetting. You may also see hospital letters before your GP has had chance to read them. What do you do if this happens and you cannot speak to your doctor/nurse immediately? Tick any that you feel apply	◯ Arrange an appointment to speak to a clinician at the earliest convenience ◯ Look at the recommended self-care website www.nhs.uk/selfcare ◯ If the practice is closed, wait and contact the practice on the next working day ◯ Panic and get worked up ◯ Contact NHS 111 to get more information ◯ Contact the Out of Hours GP Service on 01244 385300 ◯ Go to A&E for further help	
Blood test results – If your results are normal then you can continue as before. If the results are abnormal and require action we will contact you. Do you accept this arrangement?	YES	NO
Sometimes information may be recorded that is incorrect or you may believe information is missing. Would you inform the practice so that your records can be corrected?	YES	NO
Would it upset you if you read something that somebody else had said about you with regards to your health? **Information like this is usually given by someone you know well and has been done in your best interest. Ii is called third party information and your record will state who provided this and what they said**	YES	NO
Do you feel that after reading the patient access leaflet you now have a better understanding of Medical Records Access?	YES	NO

I consent to Western Avenue Medical Centre giving me access to my medical records via Patient Access

Electronic Records Viewer and agree with each of the following statement **(please tick):**

I have read and understood this questionnaire and 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 records that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	

Signed	
Date	

Please return this completed questionnaire to reception.

FOR PRACTICE USE ONLY:

Identification checked by:	
Date identification checked:	
Identification provided:	Photo ID ◯ Proof of address ◯
Name of person that scanned questionnaire and entered read code:	
Date questionnaire scanned and read code entered:	
Date confirmation email sent to patient:	