Lister House Surgery

Online Access to Medical Records Request Form. Please complete all sections

You can also view your medical record using the NHS App. Please follow the link: **Link**

To apply for online access or proxy access, please visit our website: **Link**

A. Patient Details

First Name			
Last Name			
Date of Birth			
NHS Number			
Email Address			
Contact Number(s)		Preferred Method of contact	SMS ☐ EMAIL ☐
Home Address			

B. Type of Access Requested

I am applying for full online access (please note this may take up to 2 months)	☐
I am applying for access to my medical record from the date of this form. (these request can be done within a few days)	☐
I am applying for access to view my medical record from – Date:……. (Please specify date) Accessing full records / full record retrospectively. I understand this request is added to the Practice waiting list. I understand that consideration for this may take up to two months to process as this is time consuming and could require a clinician to check each entry that has been made in my record.	
Requesting repeat prescriptions	☐

C. I wish to access my medical record online and understand and agree with each statement

1. I have read and understood the information provided by the practice
2. I agree to my username and password being sent to the email address /mobile provided
3. I will be responsible for the security of the information that I see or download
4. If I choose to share my information with anyone else, this is at my own risk
5. If I suspect that my account has been accessed by someone without my consent, I will contact the Practice as soon as possible

6. If I see information in my record that is not about me or is inaccurate, I will contact the Practice as soon as possible
7. 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.
Patient Signature Date:

Proxy Access Requests – Children under eleven years of age / relative / cared for

TO BE COMPLETED BY PATIENT IF THE REQUEST IS FOR PROXY /3RD PARTY USER ACCESS ONLY:

You will be asked to provide ID for both the requestor and patient. You will also need to provide proof of parental / caring responsibilities

PROXY ACCESS REQUESTED? The request is for online access to the areas ticked in box **B** above, and the access is being authorised for someone else other than the patient (with patient approval). The patient must read and sign the boxes in **C** above to confirm their understanding. **NB If the patient lacks capacity, please request and complete a 3rd Party User (Proxy Access) Form**	**YES / NO**
If Yes, please state the name/s and relationship/s below (e.g. legal guardian) Name/s of person to be given online access: ……..... Relationship to Patient: ……	
I, the patients' authorised representative and account user have read and understood the statements relating to the medical record in box C above and sign to confirm my adherence to the requirements outlined on behalf of the patient	Signature/s of representative/s Date