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SAUGHALL MEDICAL CENTRE
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Consent to use Patient Access online

This questionnaire goes through the main issues 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.

Please answer all the questions, deleting the answer that does not apply as appropriate. Please also use black ink as we need to scan this document onto your record. Thank you.

1.	Patient name	
2.	Patient date of birth	
3.	Email address	
4.	Home phone number	
5.	Mobile phone number	
6.	Are you completing this questionnaire for yourself?	YES/NO
6b.	If you answered NO then please state your name and relationship to the patient:	
7.	Are you registered for Patient Access allowing you to order repeat prescriptions, book appointments etc.?	YES/NO
8.	Are you happy to use a username and password to access your records? You should not share this security information. Do you agree to not share this information?	YES/NO YES/NO
8b.	If you answered NO to either question in 8, then please give your reason(s):	

9.	After attending medical appointments, you can check if the encounter has been recorded and what was discussed. Would you find this helpful?	YES/NO
9b.	If you answered NO then please give your reason(s):	
10.	When accessing your medical records online, there may be instances when you read some information that could be shocking / upsetting. You may also see hospital letters before your GP has had chance. 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 websites: http://citywallsmedicalcentre.co.uk/self-care/ ○ If the practice is closed, wait and contact the practice the next working day ○ Panic and get worked up ○ Contact NHS 111 to get more information ○ Contact the Out of Hours GP Services: 01244 385300 ○ Go to A&E for further help	
11.	**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 to make an appointment. Do you accept this arrangement?	YES/NO
12.	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
13.	Would it upset you if you read something somebody else had said about you with regards to your health? Information like this is usually given by someone you know well and done in your best interest. It is called third party information and your record will state who provided this and what they said.	YES/NO
14.	Do you feel that you now have a better understanding of Medical Record Access?	YES/NO

I consent to City Walls Medical Centre giving me access to my medical records via Patient Access Electronic Records Viewer and agree with each of the following statements (please tick)

1.	I have read and understood this questionnaire and the information leaflet provided by the practice	☐
2.	I will be responsible for the security of the information that I see or download	☐
3.	If I choose to share my information with anyone else, this is at my own risk	☐
4.	I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5.	If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐

Signature _____

Date _____

Please return this completed questionnaire with any comments to reception.
2 forms of identification will also be required (one must contain a photo).
Please see the following webpage for acceptable forms of ID:
http://citywallsmedicalcentre.co.uk/online-services/

For practice use only

Identity verified through (tick all that apply)	ID verified ☐ Photo ID ☐ Proof of residence ☐	Name of verifier:	Date:
Name of GP reviewing the application:		Access granted: Yes ☐ No ☐	Date:
Name of receptionist that: • Enabled medical record viewer (if applicable) • Sent the confirmation email to the patient (if applicable)			Date:
Name of receptionist that: • Scanned the form onto the patient's record • Added the read code			Date:
If GP denies access:	Name of receptionist that contacted patient to offer a telephone consultation with the GP to discuss their decision:		Date: