# Holbrook Surgery Application for Online Services and Electronic Consent Form

# \*Please note if the patient is between 13ys – 15yrs consent is required for access as per national guidance.\*

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address | |
| Email address | |
| Telephone number Mobile number | |

1. **SURGERY ONLINE ACCESS**

I would like access to the following online service

|  |  |  |
| --- | --- | --- |
|  | | Initials |
| Appointments | **Parent / myself** |  |
| Prescriptions | **Parent / myself** |  |
| Medical Records | **Parent / myself** |  |
|  | | |
| **DECLARATION** | | **PLEASE INITIAL EACH STATEMENT** |
| 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 | |  |
| If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | |  |
| 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. | |  |

**I ………………………………………………… have given consent to my parent for access to my appointments, medication and records and understand the can be stopped at any point. DELETE sentence if not applicable**

**Signed …………………………………… Print Name ……………………………………….. Date ……………………………**

**ENRICHED SUMMARY CARE RECORD**

There is a national data base which can, with your consent, contain a summary of your medical history which will be able to be seen by other health providers eg Hospitals, Emergency Care providers and Community Health.

This information will only be uploaded with your consent and is **SEPARATE** to our surgery online services.

|  |  |
| --- | --- |
| I would like to participate in the Enriched Summary Care Record | YES / NO |
|  | |
| **Declaration:**  I understand that signing this declaration my medical summary will be uploaded to the nation data base managed by the NHS.  **Signed………………………………………….. Date** | |

# If you would like us to contact you by text and / or email and which no. we can leave a message could you check the box below

|  |  |
| --- | --- |
| DECLARATION |  |
| I consent to you contacting me by: text e-mail | YES / NOYES |
| Preferred method of contact |  |
| I will be responsible for informing the surgery of any change in email, land or mobile phone number | |

**Signed………………………………………….. Date**

**Name and relationship if you are completing on behalf of the patient …………………………………………**

# DATA COLLECTION

# Risk Stratification

# Surgery data is analysed with hospital and social care data by the NHS using a risk stratification tool which identifies patients at high risk of hospitalisation. This group can be contacted and if necessary the correct care packages put in place to reduce the risk of them going into hospital. At the moment you cannot opt out of this collection.

# Research and Public Health

# To improve the health of the nation anonymized data is collated from the surgery to be analysed by NHS accredited bodies. This anonymised information is used by researchers to ensure treatments are safe and effective and by health planning services to ensure the NHS provides the best quality care for everyone. A unique identifier is used to link your records so your identity is fully protected. You can opt out of either or both of these collections.

# We contribute to:

# Clinical Practice Research Datalink (CPRD)

# The Health Improvement Network (THIN)

# Links for further information can be found on our website.

|  |  |
| --- | --- |
| DECLARATION |  |
| I consent to ANONYMISED data collectionCPRD | YES / NO |

**Signed………………………………………….. Date**

**Name and relationship if you are completing on behalf of the patient …………………………………………**

# For practice use only

|  |  |
| --- | --- |
| Identity Verified by Date | Type of photo ID seen & proof of residency |