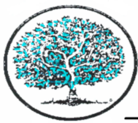

Dr A Hayat & Partners
Maybush Medical Centre

Providing NHS services

Application for Patient Online Services – FORM B

SECTION 1 – REGISTERED PATIENTS DETAILS

Title (please tick one):	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐
Forename(s):	
Surname/Family Name:	
Date of Birth (dd/mm/yyyy):	……../……./………. Male ☐ or Female ☐
Current Address:	
Postcode	
Daytime Telephone No:	
Email Address:	

Please tick one box only:

☐	I am **aged 13 to 15** and requesting access to patient online services (GP consent needed following Gillick competency test*). **Please complete section 5 & 6.**
☐	I am the parent/guardian/carer of the above named patient **under the age of 13** (or of any age and known not to be Gillick competent*) and am requesting access to patient online services for that patient. I understand that online access will cease automatically when the above named patient reaches the age of 13 or when they are deemed competent to give consent. **Please complete section 2, 5 & 6.**
☐	I am requesting access to patient online services of the above named patient (of any age) and have their consent to do so (signed consent required). **Please complete Section 2, 3, 5 & 6.**
☐	I am requesting access to patient online services for the above named patient and can confirm I am entitled to this on one of the following grounds (a formal letter of authority will be required): • I hold Lasting Power of Attorney for the patient • I am appointed as an independent Mental Capacity Advocate (IMCA) **Please complete Section 2, 4, 5 & 6.**

* Gillick competence is a term used in medical law to decide whether a patient has capacity to give consent without the need for parental permission or knowledge.

SECTION 2 – REPRESENTATIVE DETAILS

Title (please tick one):	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐
Forename(s):	
Surname/Family Name:	
Relationship to patient named in Section one	
Current Address:	
Postcode	
Daytime Telephone No:	
Email Address:	

SECTION 3 – CONSENT FOR OTHERS TO ACCESS MY PATIENT ONLINE SERVICES

I hereby give my authority for the representative named in Section 2 of this form to access patient online services.	
Signature of Patient:	Date:
Signature of Representative:	Date:

SECTION 4 – EVIDENCE OF AUTHORITY

Please indicate on what grounds you have authority to access patient online services for the patient named in section 2:

☐ Lasting Power of Attorney

☐ Independent Mental Capacity Advocate (IMCA)

☐ Other, please specify . . . .

Please note next of kin alone has no automatic rights of access to patient online services.

SECTION 5 – PROOF OF IDENTITY

In order to protect others from accessing your records without your authorisation/consent, we need to ask you to prove your identity, unless you are known to the staff member in which case we can vouch for your identity.

If you are a parent/guardian/carer requesting access for a child, you will also need to prove parental responsibility for the child by providing proof of the child's I.D:

SECTION 6 – DECLARATION

The information which I have supplied in this application is correct, and I am the patient to whom the information relates to, or a representative acting on his/her behalf.

Signature of Applicant:	Date:

PRACTICE USE ONLY

- ☐ Patient ID verified
- ☐ Access granted
- ☐ Patient advised of username/password