

Grove Medical Practice



New & Existing Patient Registration Only

In accordance with the UK General Data Protection Regulation (UK GDPR)

Guidance notes – please read before completing this form:

If a child aged 13 or over has ‘sufficient understanding and intelligence to enable him/her/them to understand fully what is proposed’ (known as Gillick Competence), then s/he/they will be competent to give consent for him/herself/themself but may wish a parent to countersign as well.

- Patients requiring access to their own record (Sections 1, 2 and 3)

Section 1: Patient details

Surname		Former name	
Forename		Title	
Date of birth		Address:	
Telephone number		Postcode:	
Email			
NHS number (if known)		Hospital number (if known)	

Section 2: Record requested

I wish to have access to the following **SystemOnline services** (please tick all that apply):

SystemOnline - Booking appointments via Booking Link	<input type="checkbox"/>
SystemOnline - Requesting repeat prescriptions	<input type="checkbox"/>
SystemOnline – Prospective access to my medical records	<input type="checkbox"/>

I wish to access my medical record online and both understand and agree with each of the following statements (tick):

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I have read and understood the information leaflet provided by the organisation	<input type="checkbox"/>
I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
If I chose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
I will contact the organisation as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
If I see information in my record that is not about me or is inaccurate, I will contact the organisation as soon as possible	<input type="checkbox"/>
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	<input type="checkbox"/>

Patient signature		Date	
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Section 3: Proof of identity

[Under the Data Protection Act 2018, you do not have to give a reason for applying for access to your own health records. However, all applicants will be asked to provide two forms of identification, one of which must be photographic identification before access can be set up.](#)

[Please speak to reception if you are unable to provide this.](#)

ADDITIONAL NOTES:

Before returning this form, please ensure that you have:

- [Signed and dated the form](#)
- [Are able to provide proof of your identity or alternatively confirmed your identity by a countersignature](#)
- [Enclosed documentation to support your request \(if applicable\)](#)

[Incomplete applications will be returned; therefore, please ensure you have the correct documentation before returning the form.](#)

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For office use only:

Identification verification must be verified through two forms of ID

- One of which must contain a photo e.g., passport, photo driving licence or bank statement

Where this is not available, vouching by a member of staff or by confirmation of information in the records by one of the management team or a partner may be used

Request received		Request refused	
Reviewed by HCP		Request completed	
Comments			
Identification of	<input type="checkbox"/> Child (aged 13-17)	<input type="checkbox"/> Patient	<input type="checkbox"/> Applicant
Identity verified by		Date	
Identity method	<input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Photo ID or proof of residence – Type <input type="checkbox"/> Vouching – by whom <input type="checkbox"/> Vouching with information in record – by whom		
Date account created		Date password sent	