**THE MICKLEOVER MEDICAL CENTRE**

**PATIENT ACCESS TO ONLINE SUMMARY CARE RECORD**

**CONSENT FORM**

**I would like Access to my Online Summary Care Record,**

* **I will register with the Practice – bringing in Photo ID and Proof of my address within the last 3 months**
* **Read about access to the records at** [**www.mickleovermedicalcentre.co.uk**](http://www.mickleovermedicalcentre.co.uk)

**PLEASE COMPLETE ALL RELEVANT INFORMATION BELOW:**

**I further agree to use the system in a responsible manner in accordance with all instructions given to me by the GP Practice and to immediately report any errors I encounter whilst using the system. If I see any patient data which does not relate to me I will immediately log out and report the matter to my GP Practice.**

|  |  |
| --- | --- |
| **Name of Patient** |  |
| **Date of Birth** |  |
| **Telephone Number** |  |
| **Mobile Number** |  |
| **Email Address** |  |
| **I am signing this consent form on behalf of someone else** | **Please indicate**  **Yes No** |

**If *yes*, please state your name below and your relationship to the patient e.g. legal guardian, have a Lasting Power of Attorney including access to the information via a GP**

**Name of Person signing on Patient’s Behalf ………………………………………………………………………..**

**Relationship to Patient ………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………**

|  |  |
| --- | --- |
| **SIGNED** | **DATED** |