**FERN HOUSE SURGERY**

**SystmOne Online Access –** Patient application form (for over 16)

Please skip this section if you do not want online access

 NAME

Date of birth (DOB)

Patient Disclaimer

I have understood and will adhere to Fern House Surgery’s guidance notes which I have been given for the use of SystmOne Online. It is my responsibility to keep my account secure by keeping my log in details confidential. I understand that I can terminate my account at any time by contacting the surgery or change my log in details by re-registering, and that this form will be kept on my electronic records.

Signed Date

The following information is optional but very useful for us to keep our records up to date:

The Department of Health require us to update smoking details for all patients over the age of 15:

I have never smoked I am an ex smoker I am a current smoker

 Smoked per day Smoked per day

Would you like support to stop smoking?  **Yes/No**

**If you are a current smoker and would like help and information on giving up, cessation advice and support is available. Please contact reception staff or see our surgery website for further information.**

Mobile number

You may from time to time receive text messages from the practice.

Please tick here if you do not wish to receive text messages

If you have other preferred methods of contact please tick the preferred method

Email Letter No Communication Other (Please clarify)

**Consent to share information** with Family/Friend/Carer/Other

Please ignore this section if you do not wish to share information

**Patient details**

Name

Address

Post Code

Date of Birth

**Family/Friend/Carer/Other details**

Relationship to patient

Name/s

Address

Post Code

Date of Birthday

Mobile/Landline

I give permission for my ……………………….. to have access to my medical records and personal details held by the practice. This permission relates to:

Full Records Part of my records Online Access

Online access which includes:

Ordering medication Booking appointments Questionnaires

Specific exclusions are:

I understand that this consent will remain in force indefinitely. However, my doctor may, at my request override this authority to allow access to my medical records at any time.

Patient

Signed Date

I will treat any information provided confidentially, I will not disclose information to a third party without agreement and will only use the information of the person that I care for in their best interest.

Family/Friend/Carer/Other

Signed Date

**Consent to Share Medical Information With a** [**Carer**](http://www.fernhousesurgery.co.uk/pages/Consent) **or Relative**

All our patients have a right to confidentiality.  This means that we do not share information about you with anyone except those working for other health and social care organisations involved with your care or except in the most exceptional of circumstances, when somebody is at grave risk of serious harm.

However, you may wish other members of your family or close friends who might be involved in your care, to be able to talk to the staff about your care on your behalf. This can be particularly useful if you find it difficult to get to the GP surgery or communication is difficult for you (such as hearing a voice on the telephone) or if that person helps to care for you.

By completing the attached Consent to Share Medical Information form will allow you to enable us to share information about your care with the person you specify on this form. We need both you and the person you would like us to share your information with to sign this form. **It is important that your** [**Carer**](http://www.fernhousesurgery.co.uk/pages/Consent) **or relative treats information about your care as confidential**.

**You have the right to allow access to all or only part of your medical information**. For instance if you have had previous medical problems you would prefer your [Carer](http://www.fernhousesurgery.co.uk/pages/Consent) or relative not to know about, you can specify this on the form. You can also override this consent to share information at a later date if you wish, for instance if you are currently undergoing treatment for a mental health condition requiring a [Carer](http://www.fernhousesurgery.co.uk/pages/Consent) to be involved and then your condition resolves.

**If you have more than one person whom you wish to give permission for us to share information with, please fill out a separate form for each and return to reception.**

**Thank you**