**ONLINE SERVICES**

**Children under the age of 13**

**PARENTAL REQUEST FORM**

Childs Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select which online services you would like to activate by ticking the relevant boxes

**BASIC ONLINE FEATURES**

Booking Appointments Ordering Repeat Prescriptions

**ENHANCED FEATURES**

Access to Summary Medical Records

Access to Detailed Medical Records

***PLEASE NOTE:*** *By ticking the access to Medical Records options, you will be able to view details of your child’s consultations and other aspects of their private medical record from the date of activation. It is your responsibility to ensure that your username and password details remain secure and you do not disclose the details to any other individual.*

**I confirm that I have parental responsibility for the child mentioned above.** I understand that by signing this consent form **I accept that it is** **my responsibility** to protect my online access username and password.

**SIGNED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The practice reserves the right to refuse or remove online access to medical records if there are substantial grounds to believe that access to medical records may be detrimental to a patient’s health or where there are substantial grounds to believe a person has been coerced into disclosing username or password details to another individual.**

**FOR OFFICE USE ONLY**

**Parents ID Type: \_\_\_\_\_\_\_\_\_\_\_ Date of Activation: \_\_\_\_\_\_\_\_\_\_\_\_ By Whom: \_\_\_\_\_\_ (please initial)**