# Request for Access to My Health Online

# to act on behalf of a child aged under 16

**Please check the appropriate box below, complete the relevant noted section on the following pages and forward the signed form to your GP Practice**

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| --- | --- | --- |
| **Ref** | **Authority** | **Check** |
| **1** | **I am the parent or legal guardian of a child under 13 years of age**  I understand I need to provide proof of my identity and the child’s identity for the GP Practice to set up a My Health Online Account. I will also provide proof of my relationship with the child if I am not registered at the same GP Practice as the child. ***(Please complete sections A and B below)*** |  |
| **2** | **I am between 13 and 16 years old and want my parent or legal guardian to be able to use My Health Online for me**  I know that I need to provide proof ofmy identity and my parent’s or guardian’s identity for my doctor in the GP Practice to set up a My Health Online Account.  ***(Please complete sections A below and C on the next page)*** |  |

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| **Section A -** to be completed by all | | | |
| **Full Name of Patient** |  | **Phone Number**  (if applicable) |  |
| **Mobile Number**  (if applicable) |  |
| **Email Address** (if applicable) |  | **Date of Birth** |  |
| **Address** |  | | |
| **Patient’s preferred language**  (please delete as appropriate) | **Welsh** | **English** | |
| **Section B -** to be completed if you ticked Box 1 | | | |
| **Full Name of** **individual acting on behalf of the patient** |  | **Phone Number** |  |
| **Mobile Number** |  |
| **Email Address** |  | **Relationship to the patient** |  |
| **Address** |  | | |
| * I confirm that I am the parent/legal guardian and have the authority to act on behalf of the patient named in Section A. * I understand that if I am currently acting on behalf of a child under 13 years of age, once the child reaches their 13th birthday my access will be revoked. If the child wishes for my access to continue, we will be required to complete a new form to confirm this. * I understand that my access is given at the discretion of the practice and can be removed at any time. | | | |
| **Signature** |  | **Date** |  |
| **Section C –** to be completed if you ticked box 2 | | | |
| **Full name of individual acting on behalf of the patient** |  | **Phone Number** |  |
| **Mobile number** |  |
| **Email Address** |  | **Relationship to the patient** |  |
| **Address** |  | | |
| *Please tick one or more of the below*  **I want my parent or guardian to be able to:**  Book and cancel appointments  Order repeat prescriptions  Update my information (for example, address and telephone number)  View a summary of my doctor’s record | | | |
| * I am happy for the person I’ve named in this section to be able to use the parts of My Health Online that I’ve ticked above. * I have been given a copy of the Information for Children and Young Adults Access to My Health Online * I know that at any time I can ask my doctor to stop the person I’ve named being able to see part or all of My Health Online Account. * I know that on my 16th birthday the person named in this section will stop being able to see My Health Online Account. * I know that any time before my 16th birthday I can ask my doctor for access to My Health Online Account and that I will need to fill in another form. | | | |
| **Patient’s Signature** |  | **Date** |  |

|  |  |  |
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| **Practice Checklist – to be completed by Practice staff**  The following checks must be completed before a nominated individual can receive access to My Health Online | | |
| **Ref** |  | **Check** |
| **1** | Patient’s and nominated individual’s identity documents verified and relationship confirmed (if required) |  |
| **2** | Details of documents checked and name of individual authenticating (if required)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **3** | Patient’s name and date of birth checked on this form validated against clinical system |  |
| **4** | Patient’s preferred language and contact details updated on the clinical system (if required) |  |
| **5** | Registration process and next steps explained |  |
| **6** | Patient Guide provided to patient and nominated individual |  |
| **7** | Nominated individual advised to register their online account over the next 24 – 48 hours |  |
| **8** | There is a process in place for access to be revoked when the patient reaches the age of 13 (if Ref 1 – Section B completed) or when the patient reaches the age of 16 (if Ref 2 – Section C completed) |  |
| **9** | Date in which access is to be revoked (13th or 16th Birthday)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |