Consent form

One application form to be completed for each person.

Surname	
First Names	Date of Birth
Address	
Email (please print)	
Home Telephone	Mobile

SUMMARY CARE RECORD	If you do not want your clinical information on the SCR complete the form, found on our website. Under "Information for New Patients" and return it to the surgery.	
SCR – Additional Information	Additional Information can help improve safe and effective care and I would like Additional Information included with my Summary Care Record.	**YES** / **NO**
Enhanced Data Sharing	**SHARING OUT -** I would like my health record at this practice to be shared with other healthcare services providing my care.	**YES** / **NO**
Enhanced Data Sharing	**SHARING IN -** I would like this practice to be able to view information in my health record that has been recorded by other healthcare services providing my care.	**YES** / **NO**
Online Access	I would like Online Access to: *If your request is approved your password Will be emailed to you*	**Appointments** **Medications** **Records** **No Access Required**
SMS Text	I am happy to receive appointment reminders, health promotion and practice news by TEXT	**YES** / **NO**
Emails	I am happy to receive health promotion and practice news by EMAIL	**YES** / **NO**

Signed …………………………………………………………………. Date ……………..…………

<u>For Practice Use Only</u>

<table>
<tr><td colspan="2">NHS Number</td></tr>
<tr><td>Identification Documents</td><td>☐ Passport

☐ Driving License

☐ Council Tax Bill

☐ Utility Bill

☐ Other</td></tr>
<tr><td>Identified by …………………………………………………………….</td><td>Date …………………………….</td></tr>
</table>

<table>
<tr><td>Online Access Granted</td><td>☐ Full

☐ Partial – medications/appointments</td></tr>
<tr><td>Authorised by ……………………………………………………….</td><td>Date …………………………….</td></tr>
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