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Your emergency care summary

Dear Patient

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the healthcare staff treating you will have immediate access to important information about your health.

As a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

- **No I do not want a Summary Care Record** – attached is an opt-out form. **Please complete the form and hand it to a member of the GP practice staff.**

If you need more time to make your choice you should let your GP Practice know.

For more information, visit the **Blackburn with Darwen Clinical Commissioning Group website** - , telephone the dedicated NHS Summary Care Record visit <https://www.blackburnwithdarwenccg.nhs> or .uk/mation Line on **0300 123 3020**, or visit their website www.nhscarerecords.nhs.uk, or contact your GP practice staff.

Additional copies of the opt-out form can be collected from the GP practice, printed from the website www.nhscarerecords.nhs.uk or requested from the dedicated NHS Summary Care Record Information Line on **0300 123 3020**.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely

Practice Manager

OPT-OUT FORM

Request for my clinical information to be withheld from the

Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title Surname / Family name:.....

Forename(s).....

Address

Postcode Phone No..... Date of birth

NHS Number (if known)

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name.....

Your signature.....

Relationship to patient

Date.....

What does it mean if I DO NOT have a Summary Care Record?

NHShealthcarestaffcaringforyou may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- Phone the Summary Care Record Information Line on 0300 123 3020;
 - Contact your local Patient Advice Liaison Service (PALS);
- or

• Contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no

Date

Ref: 4705

Your health record and sharing of information

Please read this leaflet carefully. It provides information about the choices you can make about sharing your health record. Your health record includes your medical history, details about your medication and any allergies you may have. You can now choose whether to share these full medical details.

We use a secure electronic health records system called EMIS Web. With your permission, this system can allow clinicians to share your full record held here with other healthcare services who are providing care for you. These other services will ask your permission to view your record.

Many organisations may use EMIS Web including some GP practices, out of hours services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you.

You have **two choices** which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.

Please read this leaflet and fill in your choices. You may wish to keep this section for future information.

Please note: if you have previously opted out of sharing your information via the Summary Care Record, you will still need to complete this form with your choices about sharing your health record within EMIS Web

Your choices at each practice or service

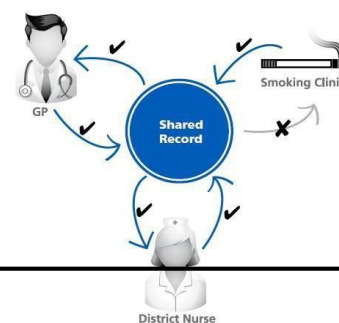
Sharing OUT - This controls whether your information recorded at this practice or service can be shared with other healthcare services.

Sharing IN - This determines whether or not this practice or service can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.

Imagine you're receiving care from three services: your GP, a district nurse and a smoking clinic. You want your GP and District Nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However, you don't want the smoking clinic to see any of your other medical information.

Your sharing choices at each practice or service would

- be: The GP can share information **IN** and **OUT**. The district nurse can share **IN** and **OUT**.
- The smoking clinic can only share information **OUT** but not **IN**.



You can change your choices at any time. Let each practice or service know. Note: You can request individual entries in your record to be marked as 'Private'. These are not shared with the rest of your record even if you choose to share out.

Please complete your details below and make your choices. Please complete a separate form for each of your dependents. Complete this section and return to the practice or receptionist.

PATIENT NAME: DATE OF BIRTH:

ADDRESS:.....PHONE:

..... SIGNATURE:
..... DATE..... **The choices you**

would like to make about sharing your health record:

SHARING OUT	I would like my health record at this practice or service to be shared with other healthcare services providing care for me.	YES / NO
SHARING IN	I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services.	YES / NO

My choices apply to my record here at PRACTICE or SERVICE

How we use your medical records

Important information for patients

- This practice handles medical records in line with laws on data protection and confidentiality.
- We share medical records with those who are involved in providing you with care and treatment.
- In some circumstances we will also share medical records for medical research, for example, to find out more about why people get ill.
- We share information when the law requires us to do so, for example, to prevent infectious diseases from spreading, or to check the care being provided to you is safe.
- You have the right to request a copy of your medical record.
- You have the right to object to your identifiable information being used for medical research and to plan health services.
- You have the right to request that any mistakes in your medical record are corrected.
- Our practice privacy notice is on the practice website which includes information on how to contact the Information Commissioner's Office to seek advice or make a complaint if you need to do so.
- For more information, please visit our website www.darwenhealthcare.co.uk



Via Patient Access we offer 24/7 online access to the practice with the option of booking routine appointments, ordering repeat prescriptions, sending non-urgent messages and other benefits.

Further details can be found on our website www.darwenhealthcare.co.uk.

PATIENT ACCESS APPLICATION FORM

I would like to register for online Patient Access, routine appointment booking & repeat prescription access service.

Surname		First Name(s)	
Address			
Date of Birth		Telephone	
Mobile Telephone		Consent to be contacted by text message/email	Yes/No
Email			

Please tick the type of access required:

Standard Access (ability to book /cancel appointments, order prescriptions, view allergies/immunisations history)

Standard Access and Coded Access

I hereby certify the information to be true. Patient Signature: Date:

Please submit this completed application form with photo identification (i.e. photo driving licence or passport) to our GP reception desk.

Your login details will either be sent to the email address provided or you will receive a message to collect from reception, please allow 5 working days to for the application to be processed. Please note: If you have requested coded access as well as standard access this will only be available once your full medical records have been received and verified by a clinician (this can take up to 12 weeks depending on the health authority), standard access will still be given in the interim period.

TO BE COMPLETED BY RECEPTIONIST

Copy of Proof of photo identification taken: **Passport** **Photo driving licence**

Staff Name: & signature: Date:

For office use only:

Application processed by: Date:

Send for scanning to patient record



THIRD PARTY CONSENT FORM

Please only complete if you wish to nominate another person to have **FULL** access to your records – access can be given for an indefinite period or a limited period of time.

PATIENT NAME:

TELEPHONE NUMBER:

ADDRESS:
.....

NOMINATED THIRD PARTY:
.....

RELATIONSHIP TO PATIENT:

TELEPHONE NUMBER:

ADDRESS:
.....

If your query involves the medical care of a patient then the consent of the patient will be required. Please obtain the patient’s signed consent below.

I fully consent to my Doctor releasing information to, and discussing my care and medical records with the nominated third party named above.

This authority is for an indefinite period / for a limited period only *(delete as appropriate)*

Where a limited period applies, this authority is valid until *(insert date)*

Signature of patient giving consent:
.....

Date: