Reviewed: 27 June 2020

UNIVERSITY SURGERY
IMPORTANT – please complete and hand to your surgery

Important information about - Care Record, Electronic Prescription Services and Patient on line

Dear Patient,

Care Record

Your practice has agreed to upload key medical information to the spine so that other health care professional can access the medical record to provide medical care. The Medical record will contain key information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past.

If you have an accident or fall ill, the people caring for you in places like accident and emergency departments and GP out of hours services will be better equipped to treat you if they have this information. Your medical Record will be available to authorised healthcare staff whenever and wherever you need treatment in England. Health care professional will ask your permission before they look at your record.

As per the new Data Protection guidelines (GDPR) please be advised that The University Surgery has updated its Privacy Notices with effect from 25th May 2018.
Copies are available to read in our waiting room and on our website www.universitysurgery.com

Patient on Line Services (POL)

What is POL – Patients can have access to online services, including appointment booking, ordering of repeat prescription and access to medical summary information and detailed medical information.

☐ **Yes**, I would like access to Patient on line services, appointments, prescriptions and brief medical summary.

☐ **No**, I do not want access Patient on Line Services

If you would like access to Patient on line services, appointments, prescriptions and a detailed medical summary, please ask at reception**. Additional form will need to be completed and photographic I.D. is required.**

PLEASE NOTE THAT YOU HAVE TO COMPLETE YOUR ON-LINE REGISTRATION FOR ON-LINE SERVICES ON THE DAY THE RECEPTION STAFF GIVE YOU YOUR LOGIN AND PASSWORD INFORMATION

(Your signature confirms that you have read and understood the above)

Full Name: …… **D.O.B:** ……

Signature:…….. **Date:** ……..
You are giving your consent to the practice to contact you via text messaging and it is your responsibility to make the practice aware of any change to your ADDRESS / MOBILE / EMAIL