**CONSENT FOR INFORMATION SHARING**

**SYSTM ONE: IT CONSENT TO SHARE INFORMATION**

To share your clinical record with authorised healthcare professionals involved in your care. You will always be asked for your permission before anybody looks at your shared medical record.

I am happy to allow this information to be shared 

I do not want this information shared 

**SUMMARY CARE RECORDS (SCR)**

SCR is an electronic record that only allows the following three aspects of your records to be shared: allergies, adverse reactions and medications. This will make it easier for you to receive prescriptions from doctors outside the practice, should you require them. No other clinical data is uploaded.

I am happy to allow this information to be shared 

I do not want this information to be shared 

**SMS TEXT MESSAGES**

Are you happy for the surgery to send you health or surgery related text messages and appointment reminders on your phone. Please tick below for your consent.

I am happy to allow this information to be shared 

I do not want this information to be shared 

**FOR CHILDREN AGES 13 – 16**

**If** a parent or guardian of a child aged 13- 16 wishes to allocate their mobile number to their child’s records, please ask the child to sign below to allow their consent to do this.

Name of Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ signed by child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am happy for my parent/s to allocate their mobile number on my records until I am 16 

I **do not** consent to the above 

**ONLINE SERVICES**

I would like to have access to online services via Systmone Online to book my appointments, order my prescriptions and view my detailed medical records. You will need to be responsible to keep your log in and password safe at all times.

Yes I would like access to online services 

No I would not like access to online services 

***I confirm that the information provided in this form is true and accurate to the best of my knowledge.***

Full name of patient (please print): ………………………………………………………..……………………..…………………………….….

Date of birth of Patient: ……………………………………………………………………………………………………………………………….….

Signed by: (Name of Parent/Guardian – if signing for Child under 16) ……………….……………………………………………

Signature: …………………………………………………………..……………………….… Date….……………………………………………………