# *Application for online access to my medical record*

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address    Postcode | |
| Email address | |
| Telephone number | Mobile number |

## I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. Access to my medical record **(SEE SECTION 1-6 BELOW)** | 🞏 |

## \*PLEASE NOTE: It may take up to 4 weeks for access to medical records to be granted. If after 4 weeks you are unable to access your medical record online please telephone the surgery and we will check with your doctor.

***I wish to access my medical record online and understand and agree with each statement***

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | 🞏 |
| 1. If I think that I may come under pressure to give access to someone else unwillingly I will contact the surgery as soon as possible | 🞏 |

|  |  |
| --- | --- |
| Print Name | |
| Signature | Date |

### *For practice use only*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | | | |
| Identity verified by | Date | Photo ID and proof of residence 🞏 | | | |
| Authorising GP | | | | | Date |
| Date account created | | | Date passphrase sent | | |
| Level of record access enabled  Contractual minimum √  Other……………………. ……… | | | | Notes / explanation | |