**Application for online access to my medical record**

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| --- |
| Full Name:  |
| Date of birth: | NHS Number:  |
| Address: |
| Email address:  |
| Telephone number:  | Mobile number:  |

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

|  |  |
| --- | --- |
| 1. Booking appointments | [ ]  |
| 2. Requesting repeat prescriptions | [ ]  |
| 3. Accessing my medical record | [ ]  |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
|  1. I have read and understood the information leaflet provided by the practice | [ ]  |
|  2. I will be responsible for the security of the information that I see or download | [ ]  |
|  3. If I choose to share my information with anyone else, this is at my own risk | [ ]  |
|  4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | [ ]  |
|  5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | [ ]  |
|  6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.  | [ ]  |

|  |  |
| --- | --- |
| Signature | Date:  |

# For practice use only

|  |  |
| --- | --- |
| Patient name  | Patient NHS number  |
| Photo Identity verified by:  |  Identity Verification Method:  Driving Licence Passport   Photo Bus Pass Student ID   Other:  Vouching  (please write below) |
| Date : |
| Access authorised by: | Date: |
| Level of record access enabledAll [ ]  Detailed coded record [ ]  Limited parts [ ]   | Notes / explanation |