**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 enabled  All  Detailed coded record  Limited parts | | Notes / explanation | |