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

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Landline 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 NHS number | | | | Practice computer ID number | | |
| Identity verified by (initials) | Date | | | Method | | |
| Vouching | | **☐** |
| Vouching with information in record | | **☐** |
| Photo ID | | **☐** |
| Authorised by | | | | | Date | |
| Date account created | | | | | | |
| Date passphrase sent | | | | | | |
| Level of record access enabled | | | Notes / explanation | | | |
| All | | **☐** |
| Prospective | | **☐** |
| Retrospective | | **☐** |
| Detailed Coded Record | | **☐** |
| Limited Parts | | **☐** |

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