



Application for online access to medical record

For patients aged 16 years and over

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	<input type="checkbox"/>
2. Requesting repeat prescriptions	<input type="checkbox"/>
3. <i>Accessing my medical record</i>	<input type="checkbox"/>

I wish to *access my medical record online* and understand and agree with each statement (tick)
(Access to medical records can take up to 21 days to authorise)

1. I have read and understood the information leaflet provided by the practice	<input type="checkbox"/>
2. I will be responsible for the security of the information that I see or download	<input type="checkbox"/>
3. If I choose to share my information with anyone else, this is at my own risk	<input type="checkbox"/>
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	<input type="checkbox"/>
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	<input type="checkbox"/>

Signature	Date
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For practice use only

Patient NHS number		Practice computer ID number	
Identity verified by (initials)	Date	Method: Photo ID and proof of residence <input type="checkbox"/> Details: Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/>	

Access to Medical Record	
Authorised by:	Date:
Level of record access enabled Limited parts (medications, allergies, immunisations) <input type="checkbox"/> Contractual minimum (medications, allergies) <input type="checkbox"/>	Notes / explanation