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	☐
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)
(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	☐
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. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
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	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method: Photo ID and proof of residence ☐ Details: Vouching ☐ Vouching with information in record ☐

Access to Medical Record

Authorised by:	Date:
Level of record access enabled Limited parts (medications, allergies, immunisations) ☐ Contractual minimum (medications, allergies) ☐	Notes / explanation