# Application for online access to my medical record

|  |  |
| --- | --- |
| 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 | 🞏 |
| 1. Requesting repeat prescriptions | 🞏 |
| 1. 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 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. 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

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified by  (initials) | Date | Method  Vouching 🞏  Vouching with information in record 🞏  Photo ID and proof of residence 🞏 | |
| Authorised by | | | Date |
| Date account created | | | |
| Date passphrase given to patient | | | |