Medical Record Online Access Application

First Name:	Surname:
Address:	
Date of Birth:	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 medications	☐
3. Accessing my medical record	☐

I wish to have access to 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. 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	☐

Access to appointments and medication will be given upon completion of this form and photo ID being presented. For access to all medical records this will be given after a GP has viewed the records and access will be given within 21 days after completion of the form.

Signature:	Date:

For practice use only

Patient identity verified by (initials):	Date	Method: Photo ID ☐ Proof of residence ☐
Authorised by:	Date	Date on-line account created:
Level of access to record enabled: Booking appointments Repeat Medication Summary Care Record Coded Entries	 ☐ ☐ ☐ ☐	Date password/user name sent: