

## Patient Access Application Form

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. Accessing my medical record	<input type="checkbox"/>

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	<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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	<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"/>
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.	<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	
Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>	
Authorised by	Date
Date account created	
Date passphrase sent	
Level of record access enabled All <input type="checkbox"/> Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> Detailed coded record <input type="checkbox"/> Limited parts <input type="checkbox"/>	Notes / explanation