ADDINGTON ROAD SURGERY

Application for online access to my medical record

Surname:	Date of Birth:
First Name:	
Address: Postcode:	
Email:	
Landline Number:	Mobile Number:

Complete if Patient is a child under 16 years or Patient has Carer.

Full Name of Proxy:
Relationship to Patient (eg. Mother, brother, Carer):
Contact if different from Patient:

I give consent for my mobile and email address to be used by the Practice to contact me. I understand that some information may be sensitive and therefore agree to keep them. ☐

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments.	☐
2. Requesting repeat prescriptions.	☐
3. Results and Investigations.	☐
4. I also wish to access my medical record online and understand and agree with each statement. *(The information is coded data and therefore may take considerably longer to be processed.)*	☐

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

Identity Verified by: (initials)	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐
Authorised by	Date

Ver 7. 29.07.2019