**Application for Online Access – Adult**

***For Data Protection purposes, the named patient must return this form in person, along with photo ID – eg passport/drivers licence***

|  |
| --- |
|  |
| Title |  | First Name |  | Last name |  |
| Gender | Male/Female | Date of Birth |  |
| Address |  Postcode |
|  |
| NHS Number |  |

|  |
| --- |
|  |
| Email Address |  |
| Home Telephone Number | Mobile Number |
|  |
| **Access requested  *(PLEASE TICK all that apply)***  |
| Repeat prescriptions |  |  |  |
| Accessing my medical record |  |
|  |  |
| **I WISH TO ACCESS MY MEDICAL RECORD ONLINE. I UNDERSTAND AND AGREE WITH EACH STATEMENT *(PLEASE TICK all of the below)***  |
| I have read and understood the information leaflet provided the Practice.  |   |
| I will be responsible for the security of the information that I see or download. |  |  |
| If I choose to share my information with anyone else, this is at my own risk. |  |  |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement. |  |  |
| 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 OFFICE USE:** |
| Photo ID Type  |  | Verified by: |  |
|  | Date: |
| Done and coded  |  | Date coded:  | Initials: |