Rowden Surgery

SystmOnline Application for Online Access to my Medical Record

|  |  |
| --- | --- |
| Name |  |
| Date of birth |  |
| Address |  |
| Postcode |  |
| Home Number |  |
| Mobile number |  |
| Email address |  |
|  (PLEASE STATE CLEARLY) |

I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
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| 1. I will be responsible for the security of the information that I see or download
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| 1. If I choose to share my information with anyone else, this is at my own risk
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| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
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| 1. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible
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|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**For practice use only**

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| --- | --- | --- | --- |
| Form taken by | Initials | Name  | Date |
| GP Signature |  | Date |
| Access Enabled Date |  |
| Patient contacted Y/N |  |