APPLICATION FOR ONLINE ACCESS TO MY MEDICAL RECORD

|  |  |
| --- | --- |
| **Surname** | **Date of Birth** |
| **First name** |  |
| **Address** | |
| **Email address** |  |
| **Telephone number** | **Mobile Telephone Number** |

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

|  |  |
| --- | --- |
| Booking appointments |  |
| Requesting repeat medication |  |
| Accessing my medical record |  |

I wish to access my medical record online and understand and agree with each statement below (***please tick if you agree to each statement***) If you do not agree then access to some aspects of the record may not be available.

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by 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 |  |
| If I suspect that my account has been accessed by someone without my agreement. I will contact the practice as soon as possible |  |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 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 |  |

Signature of patient : Date:

FOR RECEPTIONIST USE ONLY

Identity verified by :

Date:

Type of identification seen:

FOR IT DEPARTMENT USE ONLY

PROCESSED BY:

DATE: