Weobley & Staunton on Wye Surgeries

**APPLICATION FOR ONLINE ACCESS TO MY MEDICAL RECORD**

|  |  |  |  |
| --- | --- | --- | --- |
| 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):

|  |  |
| --- | --- |
| Booking appointments | 🗆 |
| Requesting repeat prescriptions | 🗆 |
| Accessing my medical record | 🗆 |

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

|  |  |
| --- | --- |
| I have read and understood the information leaflet provided by 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 | 🗆 |
| 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: |  | Date: |  |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS No: |  | EMIS No: |  |
| Identity verified by: |  | Date: |  |
| Method: | * Photo ID or Proof of Residence
* Vouching
* Vouching with Information in Record
 |
| Authorised by: |  | Coded in Notes:(Code 9RN) |  |
| Date Account Created: |  | Date Password Sent: |  |
| Level of Record Access Enabled: | * All
* Appointments
* Prescriptions
* Medical Record
* Limited parts
* Contractual Minimum
 |
| Coded in Notes: | * Provision of access to PFS (8OC)
* Registration for PFS Discontinued (8CT9)
* Access to PFS Declined (9lX)
 |
| Notes/Explanation: |  |